Texas

UNIFORM APPLICATION
FY 2009

SUBSTANCE ABUSE PREVENTION AND TREATMENT
BLOCK GRANT

OMB - Approved 09/20/2007 - Expires 09/30/2010

(generated on 10/2/2008 11:42:43 AM)

Center for Substance Abuse Treatment
Division of State and Community Assistance

Introduction:

The SAPT Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0080.

Form 1

State: Texas
DUNS Number: 807391321-

Uniform Application for FY 2009 Substance Abuse Prevention and Treatment Block Grant

I. State Agency to be the Grantee for the Block Grant:

Agency Name:	Department of State Health Services	
Organizational Unit:	Mental Health & Substance Abuse Services	
Mailing Address:	P. O. Box 149347 MC: 1911	
City:	Austin	Zip Code: 78714-9347

II. Contact Person for the Grantee of the Block Grant:

Name:	Mike Maples, Asst. Commissioner, Mental Health/Substance Abuse Svcs.	
Agency Name:	Department of State Health Services	
Mailing Address:	P. O. Box 149347, MC: 2053	
City:	Austin	Zip Code: 78714-9347
Telephone:	(512) 206-5968	FAX: (512) 206-5718
Email Address:	mike.maples@dshs.state.tx.us	

III. State Expenditure Period:

From:	9/1/2005	To:	8/31/2006

IV. Date Submitted:

Date: Original: ◉ Revision: ○

V. Contact Person Responsible for Application Submission:

Name:	Mary Sowder	Telephone:	(512) 206-5814
Email Address:	mary.sowder@dshs.state.tx.us	FAX:	(512) 206-5718

Form 2 (Table of Contents)

State: Texas

FORM 3: UNIFORM APPLICATION FOR FY 2009 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications
as required by Title XIX of the Public Health Service (PHS) Act

Title XIX of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. Formula Grants to States, Section 1921

Grant funds will be expended "only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and for related activities" as authorized.

II. Certain Allocations, Section 1922

- **Allocations Regarding Primary Prevention Programs, Section 1922(a)**
- **Allocations Regarding Women, Section 1922(b)**

III. Intravenous Drug Abuse, Section 1923

- **Capacity of Treatment Programs, Section 1923(a)**
- **Outreach Regarding Intravenous Substance Abuse, Section 1923(b)**

IV. Requirements Regarding Tuberculosis and Human Immunodeficiency Virus, Section 1924

V. Group Homes for Recovering Substance Abusers, Section 1925
Optional beginning FY 2001 and subsequent fiscal years. Territories as described in Section 1925(c) are exempt.

The State "has established, and is providing for the ongoing operation of a revolving fund" in accordance with Section 1925 of the PHS Act, as amended. This requirement is now optional.

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926

- **The State has a law in effect making it illegal to sell or distribute tobacco products to minors as provided in Section 1926 (a)(1).**
- **The State will enforce such law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18 as provided in Section 1926 (b)(1).**
- **The State will conduct annual, random unannounced inspections as prescribed in Section 1926 (b)(2).**

VII. Treatment Services for Pregnant Women, Section 1927

The State "…will ensure that each pregnant woman in the State who seeks or is referred for and would benefit from such services is given preference in admission to treatment facilities receiving funds pursuant to the grant."

VIII. Additional Agreements, Section 1928

- **Improvement of Process for Appropriate Referrals for Treatment, Section 1928(a)**
- **Continuing Education, Section 1928(b)**
- **Coordination of Various Activities and Services, Section 1928(c)**
- **Waiver of Requirement, Section 1928(d)**

FORM 3: UNIFORM APPLICATION FOR FY 2009 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications

As required by Title XIX of the PHS Act (continued)

IX.	**Submission to Secretary of Statewide Assessment of Needs, Section 1929**
X.	**Maintenance of Effort Regarding State Expenditures, Section 1930**
	With respect to the principal agency of a State, the State "will maintain aggregate State expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant."
XI.	**Restrictions on Expenditure of Grant, Section 1931**
XII.	**Application for Grant; Approval of State Plan, Section 1932**
XIII.	**Opportunity for Public Comment on State Plans, Section 1941**
	The plan required under Section 1932 will be made "public in such a manner as to facilitate comment from any person (including any Federal person or any other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary."
XIV.	**Requirement of Reports and Audits by States, Section 1942**
XV.	**Additional Requirements, Section 1943**
XVI.	**Prohibitions Regarding Receipt of Funds, Section 1946**
XVII.	**Nondiscrimination, Section 1947**
XVIII.	**Services Provided By Nongovernmental Organizations, Section 1955**
	I hereby certify that the State or Territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act, as amended, as summarized above, except for those Sections in the Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

State: Texas

Name of Chief Executive Officer or Designee: Mike Maples

Signature of CEO or Designee:

Title: Asst. Commissioner, Mental Health & Substance Abuse **Date Signed:**

If signed by a designee, a copy of the designation must be attached

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about –
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace;
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will –
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities, "in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under signed, to any **5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE** Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.	By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly. The Public Health Service strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.
SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Asst. Commissioner, Mental Health and Substance Abuse
APPLICANT ORGANIZATION Department of State Health Services	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:

☐ a. contract
b. grant
c. cooperative agreement
d. loan
e. loan guarantee
f. loan insurance

2. Status of Federal Action

☐ a. bid/offer/application
b. initial award
c. post-award

3. Report Type:

☐ a. initial filing
b. material change

For Material Change Only:

Year _____ Quarter _____

date of last report

4. Name and Address of Reporting Entity:

☐ Prime ☐ Subawardee

Tier _____ , if known: _____

Congressional District, *if known:* _____

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

Congressional District, *if known:* _____

6. Federal Department/Agency:

7. Federal Program Name/Description:

CFDA Number, *if applicable:* _____

8. Federal Action Number, if known:

9. Award Amount, if known:

$

10. a. Name and Address of Lobbying Entity
(if individual, last name, first name, MI):

b. Individuals Performing Services *(including address if different from No. 10a.) (last name, first name, MI):*

11. Information requested through this form is authorized by title 31 U.S.C. Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature: _____

Print Name: _____

Title: _____

Telephone No.: _____ **Date:** _____

Federal Use Only:

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)

DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: **Page** **of**

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks “subawardee”, then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ‘‘RFP-DE-90-001.’’

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

ASSURANCES – NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L.88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Asst. Commissioner, Mental Health and Substance Abuse
APPLICANT ORGANIZATION Department of State Health Services	DATE SUBMITTED

State: Texas

FY 2006 SAPT Block Grant

Your annual SAPT Block Grant Award for FY 2006 is reflected on line 8 of the Notice of Block Grant Award.

$135,487,606

Texas

Goal #1: Continuum of Substance Abuse Treatment Services

GOAL # 1. The State shall expend block grant funds to maintain a continuum of substance abuse treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded treatment services available in the State (See 42 U.S.C. 300x-21(b) and 45 C.F.R. 96.122(f)(g)).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

GOAL 1 – Continuum of Substance Abuse Treatment Services

The Texas Department of State Health Services (DSHS) contracts with state licensed treatment programs and other community providers to deliver services to adolescents (13-17) and adults (18 and over). This is in accordance with the block grant guidelines, the Texas Legislature and the agency strategic plan. A funding formula determines the amount of funding allocated for each of the 11 Health and Human Service Commission (HHSC) regions in Texas including the states behavioral healthcare contract, NorthSTAR, which serves the Northeast Texas area. Each region provides a continuum of the services described below.

Treatment services for adults and youth engage the client and the family in recovery efforts from outreach through treatment and continuing care. Treatment addresses the client's psychosocial and familial needs along with treating the substance abuse or dependency. Treatment approaches are research-based, holistic in design and emphasize coordination of care across the continuum. Service modalities include residential and ambulatory detoxification (for adults), intensive and supportive residential, and outpatient programs with varying intensities to meet client needs and preferences. Services include family, group, and individual counseling, as well as educational presentations and other support services. Adolescent services also include in-home and school-based counseling when appropriate, and psychiatric consultation if deemed necessary via an assessment and/or interview. Additionally, the state provides some specialized services which are described below.

Specialized female treatment services (SFS) promote individual, familial, and economic self-sufficiency for pregnant and parenting women, including women whose children are in foster care. Service intensities and types include detoxification, specialized residential for women, residential services for women and their dependent children, and outpatient services. Treatment is designed to promote stable recovery from addiction, reduce the number of infants born drug- or alcohol-dependent or affected, and improve family functioning, academic success and employment. Specialized services that contribute to the successful attainment of these goals include gender-specific counseling that addresses issues of abuse and neglect, childcare, transportation, parenting education and reproductive health care.

Pharmacotherapy services, referred to as opioid replacement therapy, is an adult treatment strategy that provides a client with the choice to use methadone or buprenorphine to facilitate higher functioning and to relieve symptoms associated with addiction to opiates or other narcotics. DSHS has worked to reduce the stigma associated with opioid replacement therapy, encourage the development of new clinical strategies, and promote individualized treatment planning. Particular attention is given to ensuring this treatment population has access to a continuum of services and is not restricted from full participation in mainstream treatment settings.

Co-occurring Psychiatric and Substance Abuse Disorders (COPSD) services are additional services provided to adult and adolescent clients with active psychiatric and substance use disorders who are receiving services in existing mental health and substance abuse treatment programs. These services are targeted to clients who require crisis resolution and/or specialized support in treatment as a result of their co-occurring diagnosis. COPSD services address both psychiatric and substance use disorders and employ stabilization, coordination and engagement strategies to help clients benefit from treatment.

GOAL 1 – Continuum of Substance Abuse Treatment Services

Intervention Services are not considered treatment but are activities instrumental in the continuum of services. These services include Outreach, Screening, Assessment, and Referral (OSAR) which provides referral to treatment and other appropriate services. The OSARs assist with movement of block grant priority populations through the continuum of care including the link between treatment and community-based support services. Additional intervention services include: Pregnant Post Partum Intervention (PPI) and HIV Early Intervention (HEI). These Services are described in more detail in goals number 3 and 6.

In addition to these specialized service programs, any provider serving an individual who is deaf can access a qualified interpreter for the hearing-impaired individual while in treatment. Interpreter services are made available to providers through an interagency agreement with the Deaf and Hard of Hearing Division of the Texas Department of Assistive and Rehabilitative Services (DARS), which subcontracts with qualified interpreters throughout the state.

FY 2006 (Compliance): In 2006, DSHS provided an array of detoxification, residential and outpatient treatment services for adults and residential and outpatient treatments services for youth in each of the 11 Health and Human Service Commission regions through contracts with 151 treatment and 61 intervention programs. Ambulatory detoxification services for adults were added to the continuum of care; specialized female programs were funded in every major population center; and at least one Co-occurring Psychiatric and Substance Abuse Disorder (COPSD) provider was funded in each region. Fifteen of the 78 licensed opioid replacement therapy programs in Texas were funded by the Department of State Health Services (DSHS). These state-funded pharmacotherapy programs were available in major population centers in 8 of the 11 HHSCC regions.

Approximately $92,061,919, 68% of block grant funds, and an additional $16,944,212 in state general revenue (GR), was spent on substance abuse treatment services. The following table shows the number of adults and youth receiving treatment services and those successfully completing treatment services in FY 2006, indicated by level of service:

	Detoxification	*Intensive Residential*	*Supportive Residential*	*Outpatient*
Adults receiving treatment	*7,897*	*10,797*	*2,285*	*22,100*
Adults completing treatment	*5987*	*7,913*	*1,819*	*12,429*
Youth receiving treatment	*NA*	*2,119*	*403*	*5,559*
Youth completing treatment	*NA*	*1,321*	*343*	*3,267*

The table includes data for the following program types:

- Treatment Adult (TRA) and Treatment Youth (TRY): Services are provided by community-based organizations through DSHS contracts.
- NorthSTAR: A program serving adults and youth in seven counties in the Dallas area that uses Medicaid, substance abuse and mental health block grant, and local funding to provide coordinated behavioral health services through a behavioral health organization for adults and youth

GOAL 1 – Continuum of Substance Abuse Treatment Services

- Texas Department of Criminal Justice (TDCJ): State general revenue-funded treatment services provided to adult probationers in the Treatment Alternative to Incarceration Program through the Community Justice Assistance Division of TDCJ
- Texas Youth Commission (TYC): State general revenue-funded treatment services provided to adolescents committed to TYC in four state facilities.

GOAL 1 – Continuum of Substance Abuse Treatment Services

FY 2008 (Progress): In FY 2008, there were 141 treatment services contracts and 59 intervention services contracts renewed to maintain the treatment services for adults and youth in all 11 Health and Human Service Commission regions of the state. This was a decrease in the number of contracts from previous years and was a result of two programs closing in the state. Other service providers received increases in their contracts in order to replace the services that were lost as a result of program closings. Therefore, the amount of services was maintained despite fewer contracts.

Rates for many treatment services were slightly raised during FY08; however there is still a gap in costs covered for services. The state continues to make deaf interpreter services available to treatment providers who are serving the hard-of-hearing or deaf clients through the interagency agreement with DARS.

The treatment continuum consists of residential and ambulatory detoxification services (for adults only), intensive and supportive residential services, outpatient services, and opioid replacement therapy services. Within the treatment continuum, services and programs are designed to meet the specialized needs of pregnant women and women with dependent children, individuals with co-occurring disorders (COPSD services), intravenous drug users (IVDUs), individuals who are addicted to opiates, and individuals at risk for or with HIV and other communicable diseases. Ambulatory detoxification services have continued. Specialized female and pharmacotherapy services and programs are funded in every major population center. At least one Co-occurring Psychiatric and Substance Abuse Disorder (COPSD) provider is funded in each region.

Youth outpatient treatment services include adolescent support services; family support services in-office and in the home; psychiatric consultation when indicated through a mental health assessment; individual and group counseling with the client and/or family; and the use of Cannabis Youth Treatment and evidenced-based models which include Motivational Enhancement Therapy, Cognitive Behavioral Therapy and Family Support Networks. A pilot buprenorphine program was established in FY 07inTravis County as an alternative to methadone treatment. Based on early positive outcomes, increased funding was allocated to this pilot in FY 2008. Finally, *Seeking Safety* an evidence-based, trauma-informed treatment model is being utilized to improve access and outcomes for pregnant women and women with dependent children. Contracts for FY 2008 include enhanced rates for all youth treatment modalities.

The following table reveals the number of adults and youth receiving treatment services and those successfully completing treatment services as of August 5, 2008, indicated by level of service. This includes data for TRA, TRY, NorthSTAR, TDCJ, and TYC programs.

	Detoxification	*Intensive Residential*	*Supportive Residential*	*Outpatient*
Adults receiving treatment	*5,688*	*8,515*	*1,727*	*19,009*
Adults completing treatment	*4,201*	*6,025*	*1,258*	*8,544*
Youth receiving treatment	*NA*	*1,242*	*225*	*3,831*
Youth completing treatment	*NA*	*787*	*171*	*1,682*

GOAL 1 – Continuum of Substance Abuse Treatment Services

FY 2009 (Intended Use): DSHS will continue efforts to increase efficiency, improve access, and enhance the quality and outcomes of behavioral health services. Emphasis will be on strengthening use of research-based practices, improving integration of physical and behavioral health services and expanding utilization use of recovery support services.

In FY 2009, a continuum of treatment services will be maintained for adults and adolescents in all 11 regions throughout the state. Any treatment provider serving a deaf client will be able to access a qualified interpreter for the hearing-impaired client during treatment.

DSHS will also seek more state funding to support additional increased reimbursement rates for services. Improved funding is a key strategy for recruiting and retaining quality treatment providers, enhancing service stability and improving client outcomes. Improved implementation and potential expansion of evidence-based treatment strategies is expected to have a positive impact on treatment and recovery outcomes. Additional funding will also be requested in order to increase the capacity of OSARS, expand prevention services, increase availability of support services, and expand availability of detoxification and residential services for persons with Co-occurring disorders. In a limited number of underserved areas, DSHS is currently experimenting with the use of telemedicine to provide client screening, intake assessment, and outpatient treatment. In FY 09, DSHS will be looking at ways to expand this service, when appropriate, for individuals in remote areas of the state.

DSHS will focus on increased flexibility for reimbursement of youth treatment services. Training and technical assistance will be provided for youth treatment providers implementing the Cannabis Youth Treatment Model, which was first offered in FY 2007 in outpatient settings. DSHS plans to expand this research-based treatment modality to youth residential services to yield improved outcomes in both outpatient and residential treatment settings. DSHS recently implemented the Trauma Informed Treatment Model for pregnant women and women with dependent children in selected programs in Texas and will be exploring ways to expand these training principals in other settings. In addition DSHS is providing training to providers for Motivational Interviewing and other researched-based best practices with emphasis on adult programs. Finally, based on the experience and data gathered from the Travis County pilot buprenorphine program, DSHS plans to seek additional funds in FY 09 to expand the these services.

Texas
Goal #2: 20% for Primary Prevention

GOAL # 2. An agreement to spend not less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies or by the Institute of Medicine Model of Universal, Selective, or Indicated as defined below: (See 42 U.S.C. 300x-22(a)(1) and 45 C.F.R. 96.124(b)(1)).

Institute of Medicine Classification: Universal Selective and Indicated:

• ***Universal:*** Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.

o ***Universal Direct. Row 1***—Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, after school program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions)

o ***Universal Indirect. Row 2***—Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.

• ***Selective:*** Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

• ***Indicated:*** Activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels. (Adapted from The Institute of Medicine Model of Prevention)

FY 2006 (Compliance):

FY 2008 (Progress):

FY 2009 (Intended Use):

GOAL 2 – 20% For Primary Prevention

FY 2006 (Compliance): In FY 2006, the DSHS spent $34,388,196 or approximately 25% of total block grant funds on primary prevention programs that served children and youth (0-17) and adults (18 and over) who did not require substance abuse treatment. Through a contract renewal process, DSHS funded 188 programs to provide primary prevention services across each of the 11 HHSC regions across the state. DSHS continued to implement prevention programs aimed at increasing resiliency and deterring or reducing the use and abuse of alcohol, tobacco, and other drugs among Texas youth and their families. In FY 2006, prevention service providers were required to provide risk and protective factor activities and report on their outcomes, which DSHS reviewed on a quarterly basis. Additionally, prevention service providers were required to report other monthly performance measure data on specific curriculum outcomes as well as key measures on the 6 Center for Substance Services (CSAP) strategies that they utilized in their programs.

- In FY 2006, DSHS reported substance abuse prevention strategies within the context of the Institute of Medicine (IOM) classifications, which included Universal Direct, Universal Indirect, Selective, and Indicated services.
- In FY 2006, DSHS maintained the Universal Direct and Universal Indirect as two separate sub-categories of the previous Universal classification. They are defined as follows:
    - **Universal (Direct)** - interventions that directly serve an identifiable group of participants, but have not been identified on the basis of individual risk. Examples include school curriculum, after-school programs, and parenting classes.
    - **Universal (Indirect)** - interventions that support population-based programs and environmental strategies including the provision of information, technical assistance, establishing Alcohol, Tobacco and Other Drugs (ATOD) policies and modifying ATOD advertising practices.

- In FY 2006, the prevention needs estimation methodology developed in FY 2005 continued to guide the Universal, Selective and Indicated allocations of the SAPT Block Grant funds, representing an effort to balance best practices, effective prevention principles, resources, needs and FY2004 expenditures for services. The regional allocation formula was applied to the IOM strategies and resulted in the following allocations for each of the 11 HHSC regions: 34% of prevention funds were directed to Universal Direct services, 14% were allocated to Universal Indirect and tobacco prevention, 23% were directed to Selective (direct) services, and 29% were directed to Indicated (direct) services.
- In FY 2006, DSHS Division continued to require providers to report key performance measures by curriculum strategy, 6 CSAP strategies and IOM classifications. DSHS continued to collect data in this manner to obtain an overview of program successes and effectiveness by program type in diverse communities throughout the state.

GOAL 2 – 20% For Primary Prevention

The chart below shows the actual expenditures and number of persons served in Prevention Programs in FY 06. The categories follow the IOM Classifications.

Target Population	Actual No. of Participants		Actual Expenditure
	Youth	Adults	
Universal Direct	422,383	52,299	$11,527,680.00
Universal Indirect (individual based services)	645,533	233,812	$4,755,889.00
Selective	163,109	34,841	$8,060,518.00
Indicated	91,914	19,144	$9,914,895.00

Universal Direct Services

In FY 2006, there were 57 programs that provided prevention services to youth, ages 5 to 17 and adults 18 and over throughout the state. Prevention providers were required to base their services and programs on logical, conceptually sound frameworks that showed evidence of effectiveness with the Universal Direct, Selected and Indicated populations.

Funded prevention programs provided activities that were aimed at increasing protective factors, fostering resiliency, decreasing risk factors and affecting critical life and social skills relative to substance abuse. All providers funded for Universal Direct services targeted the general population and provided education and training that focused on skills building and skills practice. This was part of a structured curriculum to enhance protective factors and reduce risk factors. Universal Direct activities and services included, but were not limited to, the following services and activities: life skills training series, series of classroom lessons, and sequential small group sessions. These sessions followed a structured evidence-based curriculum, built on skills in a sequential manner, and offered culturally- and developmentally-appropriate objectives for the target population. Sessions were delivered in appropriate and adequate duration and intensity according to the age, gender, ethnicity and other needs of the target population to maintain program fidelity.

Universal Indirect Services

In FY 2006, Universal Indirect services and activities were provided through 28 contracts with entities throughout the state including Prevention Resource Centers, Community Coalitions, and the Coordinated Statewide Training Services. These entities incorporated media campaigns and training strategies as follows:

Prevention Resource Centers (PRC) The DSHS-MHSA Division funded one PRC in each of the 11 Health and Human Service Commission (HHSC) regions to support a statewide strategy to disseminate information to communities throughout the state. This was done throughout the year via a wide range of prevention education materials distributed to schools, communities, prevention providers, churches, professional associations, colleges, universities, and other interested groups. Each PRC maintained a website, a clearinghouse or resource library, and a statewide toll-free number to provide information about prevention. PRCs also disseminated information to communities throughout the state via speaking engagements to civic organizations, schools, parent organizations and at health fairs. Many PRCs also generated monthly or quarterly newsletters and resource directories, as well as brochures, telephone

information services, speaker bureaus and Internet services. In support of the PRC's, DSHS's library and clearinghouse and the DSHS-MHSA web page offered information on regional substance use and abuse, providing a comprehensive source of information. The MHSA web page includes federal, state and local resources; as well as, research, media campaigns and information in both English and Spanish.

In FY06 the PRC's continued providing education for retail stores about the laws on minors and tobacco. This process resulted in a dramatic increase in the number of retail stores contacted and informed about the Texas Tobacco Laws pertaining to their establishments (12,565 retail stores were contacted in 2006). In addition, 1,973 presentations were held on the legal consequences and harmful effects of tobacco youth which were attended by 50,195 youth and 13,056 adults. Additionally, PRCs conducted media awareness activities to create public awareness of ATOD-related issues. These activities included, but were not limited to, public services announcements, television interviews, billboards, editorials, and news articles.

DSHS continued the statewide campaign "2Young2Drink" that included a billboard advertisement component and a series of public awareness events, which targeted the prevention of underage drinking. Additionally, the PRCs led the state in the Red Ribbon Campaign in the regions and provided support for the schools and other programs in their communities.

Each PRC assisted the Prevention Training Services (PTS) contracted entity with a regional training needs assessment for substance abuse prevention and HIV. The PRC's provided space for staff and recruited volunteers to assist with surveys. Once the needs assessments were completed, the PRC's assisted with the logistics for local trainings.

The chart below documents the breakout of PRC tobacco activities for FY 06.

Activity Type	No. of Participants Served or No. of Activities Completed
Number of youth and adults receiving ATOD information	Youth - 592,039 Adults - 217,592
Media Awareness Activities - ATOD	813
Tobacco Presentation pertaining to minors and tobacco Youth and Adults attending minors and tobacco presentations	1973 Youth – 50,195 Adults - 13,056
Media Contacts pertaining to tobacco	653
Tobacco Retailer Compliance Checks	12,656
No. of Written Community Agreements	311

GOAL 2 – 20% For Primary Prevention

Community Coalitions (CCP)

In 2006, DSHS/MHSA Division renewed funding contracts with 15 community coalitions. The primary mission of these coalitions was to reduce the illegal and harmful use of alcohol, tobacco and other drugs with primary emphasis on reducing youth usage. The coalitions consisted of collaborative partnerships working towards prevention and reduction of illegal and harmful alcohol, tobacco and other drug use by implementing community based and evidence based environmental prevention strategies. These strategies impact the social, cultural, political and economic processes of communities across Texas.

The coalitions' environmental strategies focused on establishing or changing standards, codes and attitudes within communities. The activities included providing assistance to communities in monitoring the enforcement of laws relative to the sale of alcohol and tobacco to minors; developing drug-free school zones; providing alcohol and tobacco education for retailers; developing local ordinances to restrict the location of establishments selling alcohol, creating messages for billboards, helping to develop comprehensive school policies; providing technical assistance and information to schools and businesses; and educating policymakers about the needs and gaps in substance abuse services. The 15 coalitions funded included a target population of 5,500,000 residents in the 31 counties served.

Coordinated Training Services (CTS)

In FY 2006, DSHS-MHSA renewed their contract with a single training entity to conduct regional statewide prevention trainings on evidence-based curriculum, HIV, community mobilization, and environmental strategies. The Prevention Training Services (PTS) is the substance abuse prevention training part of the Coordinated Training Services contract. PTS coordinated with the 11 regional PRCs and Education Service Centers (ESCs) to provide appropriate regional trainings as determined by the annual regional training needs assessment. The entity subcontracted with the developers of curricula and designated trainers to provide local training based on the needs of the Universal, Selective and Indicated populations in Texas, which resulted in more cost effective management of evidence-based curricula training. In 2006, the training entity offered 133 trainings, which included 47 evidence-based program trainings attended by 2,177 prospective instructors and 32 coalition trainings attended by 430 adults and 200 youth. There were also 40 Peer Assistance Leadership and Peers Making Peace programs for youth, training a total of 2,011 youth. In addition, PTS offered fourteen 16-hour prevention staff trainings that were available to all the employees of DSHS-MHSA-funded contractors. These trainings, held in all 11 regions of the state, throughout the year, were requested by the PRCs based on the needs of the communities. PTS coordinated with DSHS, handled registration and provided on-site support for the DSHS Third Annual Prevention Provider Meeting on November 16, 2006, and the DSHS Annual CCP/SPF Coalition Meeting on November 17, 2006.

A second part of the CTS contract is the HIV Training Services (HTS) which provides training on HIV/AIDS, TB, Hepatitis and other Communicable Disease. The HTS also provides training on issues related to working with persons at risk for or infected with communicable diseases. Additionally, the HTS coordinates for DSHS an annual HEI Conference, HIV Conference and assists with the coordination of the statewide HIV/STD Conference. More details related to the HTS are found in goals description #5 and #6.

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Other Professional Development Events

In November 2006, DSHS co-sponsored the "Partners in Prevention 6th Annual Conference" at the Doubletree Hotel in Austin, which participants attended as part of a community team. In addition, DSHS sponsored the 49th Annual Summer Institute in Austin. The week long Institute included a comprehensive prevention track consisting of the basic 40-hour course for the Certified Prevention Specialist credential. Forty-six participants attended the Prevention Specialist Track at the Summer Institute.

In FY 2006, the Southwest Center for Application of Prevention Technologies (SWCAPT) at Norman, Oklahoma continued to support a Texas State Liaison position to provide training and technical assistance for prevention specialist training. DSHS provided office space, equipment, technical support and oversight for the position. This collaborative arrangement served to promote workforce development goals across the prevention field.

Prevention Media Campaign (PMC). In FY 2006, DSHS continued to fund the Partnership for a Drug Free Texas (PDFT), a statewide media campaign designed to shape attitudes about the use of alcohol, tobacco and other drugs; stimulate public support for and development of community coalitions against alcohol, tobacco and other drugs; and communicate the value and role of substance abuse prevention and treatment to the general public. The PDFT developed the prevention media campaign which included nationally produced public service television announcements that were tagged with local PRCs contact information. These public service announcements were in English and Spanish.

The PMC also included weekly radio news stories on substance use and abuse issues to radio stations across the state. The Texas Drug Free Radio News provided access to a weekly 60-second prevention news story to approximately 400 radio stations across the state reaching more than one million listeners. The PMC also included the production and distribution of culturally-appropriate posters and other statewide resources for the annual state Red Ribbon Campaign. In addition, DSHS provided a statewide toll-free number, 1-877-9 NO DRUG, for information and referrals. This number was published on the DSHS website, as a tag line to PMC public service announcements, and as part of the *2Young2Drink* campaign, which is a collaborative effort of public and private sector organizations that work with local leaders to address underage drinking.

In its fourth year, the **Drug Demand Reduction Advisory Committee (DDRAC**), a legislatively established committee with a mandate to develop a comprehensive statewide strategy and make legislative recommendations to reduce drug demand in Texas continued its efforts. The State mandated that 16 state agencies participate in this effort, as well as five at-large members from different geographical areas within the state. DDRAC continued to conduct numerous initiatives to build on the legislatively-mandated statewide strategy to reduce drug demand in Texas. Member agencies reached a consensus on the mission, principles, philosophy, goals, and actions to meet the strategic objectives. This was a demonstration of the effectiveness of a multi-faceted statewide strategy. Significant progress was made in strengthening community coalitions, building public and private partnerships involving community organizations, developing outcome-based services, and coordinating among community organizations.

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Selective Services

There were 51 programs that provided services that targeted children and youth at higher than average risk for substance abuse (at-risk and high-risk children and youth). These were classified by the IOM system as Youth Prevention Selective (YPS). These programs provided a structured curriculum and included services and activities such as life skills training provided in a group setting in schools and communities. There were also mentoring programs aimed at children with school performance or behavioral problems, and children of substance abusers who require one or more of these types of activities or services.

Indicated Services

There were 51 programs funded to prevent chronic use and target children and youth already using substances or engaged in other high risk behaviors (such as delinquency). These are classified by the IOM system as Indicated. In these DSHS system these are designated as Youth Prevention Indicated (YPI) programs and they provided activities and services to include structured evidence-based curriculum and one-on-one sessions with individuals.

In FY 2006, DSHS renewed the ***Texas-Mexico Rural Border*** *Initiative (RBI).* Though not solely a prevention initiative, most of the RBI work since FY 2005 focused on prevention efforts designed to increase service availability and workforce capacity in rural and isolated communities. The RBI funded contracts enabled providers to continue to offer unique programs and services along the Texas-Mexico border from El Paso-Ciudad Juarez to Brownsville-Matamoros. The RBI had a total of three projects serving a total of 15 counties, including colonias, in HHSC Regions 8, 10, and 11. These unique programs involved a three-fold approach which included primary prevention and utilized evidenced-based school curriculums for prevention of substance abuse among youth, screening and intervention (short term) services for individuals abusing substances (i.e. youth and/or their parents), and a community-wide approach which enhanced local community action and established links to existing resources. These initiatives were closely linked to the Outreach and Substance Abuse Referral (OSAR) Centers funded by the DSHS and the CSAP Strategic Prevention Framework-State Incentive Grant (SPF-SIG) community coalitions.

The programs provided services with a special emphasis on strengthening ties among substance abuse and other public health programs, creating support for locally developed prevention strategies. The Border Strategic Plan continued with three rural border projects providing outreach, screening, referral and follow-up care services using a public health model. DSHS continued to participate in a statewide effort to track interagency services provided to the residents of the colonias in the border counties. Additionally, DSHS staff coordinated with Southwestern CAPT to offer the Substance Abuse Prevention Specialist Training (SAPST) to the bi-national community coalition in Del Rio for 30 coalition members. The Western CAPT Alliance for U.S.-Mexico Border Communities also coordinated with DSHS staff and contractors to build capacity for training and offered technology transfer support.

The DSHS also trained 45 people Promotoras (Community Health Workers – trained outreach workers from the target population) who were instrumental in delivering services with the appropriate cultural and linguistic requirements for the Texas-Mexico border regions. These special projects have successfully developed resources and networks, creating strong alliances

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between HHSC's Colonias Initiative, DSHS' Office of Border Health, and Texas A&M University (TAMU) Colonias Projects (CHUDs). The agencies' combined efforts leveraged the quantity and quality of services available, significantly increasing access to health and social services in the rural border areas. The combined effort raised the level of awareness, educating these communities about prevention, which in turn, promoted recovery, improving the quality of life within the community. This effort increased the number of people in these communities receiving treatment services and intervention counseling for issues related to alcohol, tobacco and other drug use.

DSHS required reports of key performance measures associated with the RBI project. The measures were reported monthly and collected in the DSHS BHIPS data system. In 2006, the Texas-Mexico Rural Border Initiative served 656 youth and 575adults.

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FY 2008 (Progress): In FY 2008, the DSHS is completing the final year of contract renewals for service providers funded in FY 2005. The division will complete a competitive FY 2009 Behavioral Health Prevention Services Request for Proposal (RFP). The providers submitted applications for evidence-based curricula and effective CSAP strategies in schools and community-based sites for services to be delivered beginning in FY 09.

Currently, in FY 2008, providers are serving 1,047 school sites and 158 community sites to prevent the use and consequences of alcohol, tobacco and other drugs (ATOD) among Texas youth and families. In over 500 school districts, community-based programs are providing evidence-based curricula and using the 6 evidence-based prevention strategies identified by CSAP. The prevention framework which was implemented in FY 2005 continues to provide a continuum of services that targets the three Institute of Medicine (IOM) classifications of prevention activities, including Universal, Selective, and Indicated.

The prevention needs estimation methodology developed in FY 2005 is still being used in FY 2008 and continues to guide the allocation of block grant funds in each of the 11 Health and Human Service Commission regions. The FY 2008 allocations are as follows: 34% of prevention funds are being directed to Universal Direct strategies and services, 12% on Universal Indirect, 25% of prevention funds are being directed to Selective services, and 29% of prevention funds are being directed to Indicated services.

In FY 2008, DSHS anticipates that it will spend $33,914,121.00 of block grant funds for primary prevention activities that serve children and youth (0-17) and adults (18 and over) who did not require substance abuse treatment, which will exceed the requirement to expend at least 20% of the SAPT BG on primary prevention activities. In FY 2008, DSHS is funding 190 program providers to provide primary prevention services in each of the 11 service regions across the state, implementing Universal Direct, Selective, Indicated and Universal Indirect strategies. Services will continue through the end of FY 2008. DSHS continues to implement prevention programs aimed at increasing resiliency and deterring or reducing the abuse or use of alcohol, tobacco, and other drugs among Texas youth and their families. Prevention programs continue to use curricula that address risk and protective factors. Programs submit quarterly outcomes which are reviewed by DSHS. Additionally, DSHS continues to collect and review performance measure data and reports are submitted monthly by providers. Below is a chart that shows the projected numbers served and expenditures through July, 2008 based on the IOM classifications.

The following information is annualized based on data available as of July, 2008.

Target Population	Projected No. of Participants		Projected Expenditure
	Youth	Adults	
Universal Direct	173,612	22,421	$11,545,340.00
Universal Indirect	660,210	217,150	$4,187,588.00
Selective	65,990	18,000	$8,371,652.00
Indicated	33,955	10,305	$9,809,541.00

In FY 2008, all DSHS funded prevention providers continue to base their programs on a logical, conceptually-sound framework that indicates evidence of effectiveness within the specific target population they serve. These programs implement curriculum that is culturally and linguistically appropriate for the target population and their community.

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Additionally, funded prevention programs provide activities aimed at increasing protective factors, fostering resiliency, decreasing risk factors and affecting critical life and social skills relative to substance abuse.

All Universal, Selective and Indicated direct providers continue to use and report on the six CSAP strategies.

Universal Direct Services

Fifty six funded providers of universal direct services are targeting the general population, providing education and skills training that focus on building and practicing skills as part of a structured curriculum to enhance protective factors and reduce risk factors. Universal Direct programs include, but are not limited to, the following activities: life skills training series, series of classroom lessons, and sequential small group sessions. These sessions follow a structured evidence-based curriculum, build on skills in a sequential manner and offer culturally and developmentally appropriate objectives for the target population. Sessions are being delivered in an appropriate and adequate duration and intensity according to the age, gender, ethnicity and other needs of the target population.

Indirect Services to the Universal Population

Universal indirect activities and services are being provided through 29 contracted programs. These programs are Prevention Resource Centers (PRC), Community Coalitions (CCP), Prevention Training Services (PTS) and Prevention Media Campaign Services (PMC). Each of these are described below.

Prevention Resource Centers (PRC)

The Department of State Health Services (DSHS) continues to fund one PRC in each of the 11 Health and Human Service Commission (HHSC) regions. Each PRC contractor supports local and statewide prevention alcohol, tobacco and other drugs (ATOD) efforts by providing local communities with a source of prevention materials, information and expertise. The PRCs distribute a wide range of prevention education materials to schools, communities, prevention providers, churches, professional associations, colleges and universities, and other interested stakeholders. Each PRC maintains a website, a clearinghouse or resource library, and a statewide toll-free number (1-888-PRC-TEXX) to provide information about ATOD prevention. PRCs disseminate information to communities throughout the state via presentations to civic organizations, schools, parent organizations and at health fairs. The PRCs also generate newsletters, resource directories, brochures, book marks, referral information resources, and speaker bureaus that are made available to the general community.

In support of the PRCs, DSHS provides a library and clearinghouse. Also, DSHS has a web page dedicated to information on regional substance use and abuse, providing a comprehensive source of information. The MHSA web page includes federal, state and local resources, as well as, research, media awareness campaigns and information in both English and Spanish.

GOAL 2 – 20% For Primary Prevention

Each PRC works collaboratively with the statewide Prevention Training Services contractor (PTS) to facilitate FY08's regional training needs assessment and assisted with the prevention training in their region.

In 2008, the PRCs continue to provide retail compliance checks and education on minors and tobacco laws and the affects and how they pertain to their establishments. Additionally, 10 PRC contractors received a one-time funding for the last 2 months of FY 2008 from the MHSA Division Tobacco Prevention Program. The PRC contractors are providing community education related to smokeless tobacco prevention and tobacco use cessation targeting youth in rural areas of service as mandated by the Legislature for FY 2008.

The chart below documents breakout of PRC tobacco activity through June 2008.

Activity Type	No. of Participants Served or No. of Activities Completed
Number of youth and adults receiving ATOD information	Youth – 516,288 Adults - 187,681
Media Awareness Activities - ATOD	1,684
Tobacco Presentation pertaining to minors and tobacco Youth and Adults attending minors and tobacco presentations	2,030 Youth – 68,131 Adults – 14,337
Media Contacts pertaining to tobacco	653
Tobacco Retailer Compliance Checks	9,776
No. of Written Community Agreements	372

Community Coalitions (CCP)

Through a contract renewal process, DSHS continues to fund 15 community coalitions whose primary mission is to prevent and reduce the illegal and harmful use of alcohol, tobacco and other drugs in communities across Texas. The primary emphasis is on reduction in youth use by promoting and conducting community-based and environmental strategies. Activities are centered on establishing or changing standards, codes and attitudes within communities. These environmental strategies include assistance to communities in monitoring the enforcement of laws relative to the sale of alcohol and tobacco to minors, developing drug-free school zones, and providing alcohol and tobacco education for retailers. Other strategies include developing local ordinances restricting placement of alcohol establishments and billboards, helping to develop comprehensive school policies, providing technical assistance and information to schools and businesses, and educating policymakers of needs and gaps in substance abuse services. Collectively, it is projected that the coalitions will impact communities whose total population is approximately 5,500,000 county residents.

GOAL 2 – 20% For Primary Prevention

Prevention Training Services (PTS)
In 2008, DSHS continues to contract with a single training entity through a contract renewal process to provide statewide prevention training on evidence-based curricula, cultural competency, adolescent development, risk and protective factors, strengthening families, communicable diseases, community mobilization, environmental strategies, and leadership and management development. The entity coordinates with 11 regional PRCs and Education Service Centers (ESCs) to provide appropriate regional trainings as determined by regional provider training needs assessments. The entity subcontracts with the developers of curricula and/or designated Texas trainers to provide local training based on the regional needs of the universal, selective and indicated populations in Texas resulting in cost effective management of evidence-based curriculum training.

As of July 2008, the PTS offered 44 evidence-based curriculum trainings attended by 1,877 prospective instructors, 34 coalition trainings attended by 644 adults and 200 youth, and 49 Peer Assistance Leadership and Peers Making Peace programs trainings attended by 3,156 youth participants. In addition, PTS offered fourteen 16-hour prevention staff trainings that were available to employees of all DSHS funded contractors. The trainings were held regionally as requested by the PRCs throughout the year based on needs of the communities.

Other Support Provided by PTS:
PTS provided support for the DSHS 3rd Annual Prevention Provider Meeting, November 14, 2007, and DSHS Annual CCP/SPF Coalition Meeting, November 15-16, 2006 by coordinating with DSHS, handling registration, and providing on-site support in Austin on May 22-28, 2008 that was attended by approximately 500 participants.

Additional Professional Development Opportunities
In FY 2008, DSHS co-sponsored the 7th Annual Partners in Prevention conference in which between 450-500 participants were expected to attend as part of a community team.

While no block grant dollars were directed at this activity, DSHS sponsored the Texas Behavioral Health Institute *Knowledge in the Neighborhood: Partnerships to Healthy Communities*, providing a comprehensive prevention track consisting of the basic 40-hour course of preparation for the Certified Prevention Specialist credential with 50 participants completing the training. The conference provided an estimated 27 continuing education hours to include: HIV, Hep C, Ethics, and numerous prevention and mental health trainings and pre-conference continuing education opportunities. The Institute also offered a week long Coalition Summit and expected an estimated 55 participants to complete this training. Nine different concurrent session tracks on criminal justice issues, nonprofit leadership, community issues, and skills building workshops were made available.

In FY 2008, DSHS continued to provide office space, equipment, technical support and oversight to the Southwest Center for Application of Prevention Technologies (SWCAPT) at Norman, Oklahoma for the Texas State Liaison position to provide information and technical assistance on the Prevention Specialist Training module. The collaborative arrangement serves to enhance workforce development efforts for the prevention field.

GOAL 2 – 20% For Primary Prevention

As a result of this collaborative effort between DSHS and the Southwest CAPT, a total of 257 prevention specialists received the 40-hour state-required prevention specialist training. The participants who were employees of contracted providers will continue to participate in training and will work to obtain the Prevention Specialist Certification.

Prevention Media Campaign (PMC)
DSHS continued to fund the Partnership for Drug Free Texas (PDFT), a statewide media campaign designed to shape attitudes about the use of alcohol, tobacco and other drugs. Its goal was to stimulate public support for and develop community coalitions, communicating the value and role of substance abuse prevention and treatment to the general public. Through the Partnership for a Drug Free Texas, the PMC utilized the Partnership for a Drug Free America television and radio public service announcements tagged with Texas-specific referral information, and produced a number of public service radio announcements.

The PMC also provided weekly radio news stories on substance use and abuse issues to radio stations across the state. The Texas Drug Free Radio News provided access to a 60-second weekly prevention news story to approximately 400 radio stations across the state reaching more than one million listeners. Through the PMCs, DSHS also produced and distributed culturally-appropriate posters and other resources, and led the annual State Red Ribbon Campaign. In addition, DSHS provided a statewide toll-free number (1-877-9 NO DRUG) for information and referrals. This was published on the DSHS website as a tag line to the PMC public service announcements and as part of the 2Young2Drink campaign, which is a collaborative effort of public and private sector organizations that work with local leaders to address underage drinking.

Selective Services
Fifty four programs were funded that target those at higher than average risk for substance abuse and are identified by the IOM Classifications as Selective. Selective programs continued to provide the following services and activities: structured evidence-based curriculum in schools and communities, mentoring programs aimed at children with school performance or behavioral problems, and programs for children of substance abusers that include a combination of structured curricula for education and skills training, mentoring and other relevant services.

Indicated Services
There continued to be programs that target individuals already using or engaged in other high risk behaviors (such as delinquency) to prevent chronic use are identified by the IOM classifications as Indicated. In FY 08 there are 51 indicated programs that provide services and activities, including structured evidence-based curricula and one-on-one sessions with the individual.

The ***Rural Border Initiative (RBI),*** while not solely a prevention effort**,** works to create and expand services along a continuum of substance abuse prevention, intervention, and treatment, while at the same time strengthening individuals, families and communities through mobilization and empowerment. The projects provide ATOD prevention curriculum and skills training in the schools, referrals to services, assessments, short-term intervention counseling and referrals to OSARs.

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Through July 2008, the RBI has provided services to 1,236 adults and 1,273 youth. A total of 443 adults received training. In addition, approximately 90 youth and 290 adults were referred to treatment or other support services.

The FY 2008 contract renewals put a greater emphasis on border region Community Health Workers (CHWs), also known as Promotoras. New contractual language was written with this workforce in mind. DSHS continues to develop training opportunities for the CHWs on substance abuse and mental health. Additional training will facilitate referrals and increase utilization of services. The Rural Border Coordinator in the Mental Health and Substance Abuse Division of DSHS was certified in FY 2008 as Promotora Instructor and trained over 75 CHWs in the border region .She trained the promotoras on a six-hour CHW-certified curriculum specifically relating to substance abuse and mental illness.

DSHS staff participate in an interagency HHSC Colonia Initiative Workgroup. The workgroup meets quarterly to work on increasing service availability and accessibility to Colonia residents. DSHS actively participates in a statewide interagency effort to track services provided to residents of the colonias in the border counties. As part of the tracking initiative, in 2008, DSHS developed a new quarterly reporting format for its mental health (MH) services in the border regions. This report indicates the number of Colonia residents receiving MH services. In addition, all DSHS substance abuse prevention providers report the number of Colonia residents being served on a monthly basis through Behavioral Health Integrated Provider System (BHIPS). This information will be quantified by amount of state dollars spent and provided to the Texas Legislature as they evaluate the services and needs of Colonia residents.

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FY 2009 (Intended Use): In FY 2009, the DSHS projects to spend approximately $38 million of block grant funds on primary prevention programs serving children and youth (0-17) and adults (18 and over) who do not require substance abuse treatment. Through a competitive Request for Proposals (RFP) process, DSHS received over 400 applications to provide direct and indirect primary prevention services in each of the 11 HHSC regions across the state. The DSHS will implement prevention programs with the objective of providing effective education activities designed to affect critical life and social skills related to the prevention of substance use and mental health related disorders. This, in turn, will increase resiliency and deter or reduce the use and abuse of alcohol, tobacco, and other drugs among Texas youth and their families. The principles of the Strategic Prevention Framework (SPF) were introduced to the block grant applicants through the competitive request for proposals (RFP) process. The RFP required the applicants to begin their application with a systematic assessment of their prevention needs, identification of capacity resources, development of strategic plan, and evaluation of the data-driven selected outcomes. The proposal template for the RFP followed the SPF process in identifying the needs of the local schools and communities and the steps to address the needs. In addition, a comprehensive, multi-strategic approach was also required to provide prevention services that incorporate the six (6) effective CSAP strategies. In addition, the DSHS will utilize a behavioral health framework which allows for efficient, cost-effective and culturally-appropriate prevention services for substance abuse and other mental health related disorders. The behavioral health framework will provide a system to promote prevention of substance abuse and other related mental health disorders. It will further enhance the state's ability to provide a comprehensive continuum of services, promoting individual, family, and community health. Services are designed to prevent substance abuse, promote mental health, support resilience, foster recovery, promote treatment, and prevent relapse.

In FY 2009, DSHS projects the following services and expenditures for primary prevention services:

Target Population	Projected No. of Participants		Projected Expenditure
	Youth	Adults	
Universal Direct	450,470	55,085	$11,356,543.00
Universal Indirect	569,595	201,277	$4,685,284.00
Selective	175,438	29,577	$7,940,853.00
Indicated	101,705	127,920	$9,767,700.00

In FY 09, DSHS estimates that 240 programs will be awarded funds to provide 100% evidence-based programs to the Universal, (Direct/Indirect), Selective and Indicated target populations throughout the 11 service regions across the state. The goal of these programs will be to prevent the use and consequences of alcohol, tobacco and other drugs (ATOD). The program requirements and activities will also include the tobacco Synar Survey. Services will be based on the national Institute of Medicine (IOM) model that recognizes the importance of a spectrum of interventions and strategies. The prevention framework will be implemented through a continuum of services that target Universal Direct (80 entities), Universal Indirect (36 entities), Selective (69) and Indicated (55) services, and require the use of the six CSAP strategies and evidence-based curriculum.

All DSHS primary prevention providers will be required to implement programs using evidence-based prevention curricula, designed to promote mental health and prevent related challenges in communities by reducing risk factors and increasing protective factors. Additionally, the

GOAL 2 – 20% For Primary Prevention

program types and curricula used will specifically target the universal, selective and/or indicated populations. Both youth (under age 18) and adults (18 years or older) will be served by prevention programs and activities.

Universal Direct , Selective and Indicated Services

In FY 2009, the DSHS projects a total of 450,470 youth and 55,085 adults will be served through direct programs, services and activities. The entire state population is expected to be served through universal indirect activities and strategies during FY09. DSHS will monitor the expenditure of block grant with expectation of spending approximately 25% on primary prevention. The DSHS contractors will implement prevention activities aimed at increasing resiliency and deterring or reducing the abuse, use and onset of alcohol, tobacco, and other drugs among Texas youth and their families.

DSHS will contract for the services of evidence-based prevention curricula and effective prevention strategies. All funded prevention programs will be required to provide sound education activities designed to affect critical life and social skills. The prevention of substance use and mental health-related disorders will utilize the national Center for Substance Abuse Prevention – National Registry of Evidence-based Programs and Practices (CSAP/NREPP) with a designation of legacy Effective, Promising or Model curricula or the curricula from the more current approved NREPP process. Although a major portion of the IOM categories are delivered in classrooms, DSHS will require primary prevention providers to include the 6 CSAP strategies within their programs. The programs and activities will target universal direct, selective and indicated populations. Additional services specific to tobacco prevention with minors are contractually required to account for work in tobacco prevention. This accounting is separate from alcohol and other drug prevention.

Additionally, through the competitive Request for Proposals (RFP) process, DSHS will fund five **Rural Border Initiative (RBI)** project applications. Again, while not solely a prevention activity, the focus of the RBIs will be on integrating health, mental health and substance abuse prevention, intervention and treatment. The DSHS will implement rural border programs to include evidence-based prevention curriculum with the objective of providing sound education activities. The concept is designed to affect critical life and social skills related to the prevention of substance use and mental health-related disorders, thus increasing resiliency and deterring or reducing the use and abuse of alcohol, tobacco, and other drugs among Texas youth and their families.

The Rural Border Initiative (RBI) is designed to develop and implement a comprehensive behavioral health model that promotes and embraces culturally appropriate prevention, intervention and treatment services for youth and adults in rural border area (including colonias) of the state. The Texas Border region covers 1,254 miles from El Paso-Ciudad Juarez to Brownsville-Matamoros. Services will be provided across 24 counties located in four Health and Human Service Commission Regions 8, 9, 10, and 11. The target population includes:

1. Members of communities in the rural border counties,
2. High risk youth/adults and their families/significant others, and
3. Community coalitions, Colonia-based projects, community centers, existing service networks, and schools in the targeted Texas-Mexico border areas.

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The RBI will utilize the six CSAP strategies to achieve the implementation of effective programming. RBI providers will select a DSHS-MSHA Division-approved, evidenced-based curriculum that is culturally and linguistically appropriate and relevant to the specific target population. Providers will also employ evidence-based intervention strategies with adults who are identified but are unready to accept treatment. Providers will use the Prochaska-DiClemente Transtheoretical Model (Stages of Change) and Motivational Enhancement (motivational interviewing) strategies to support these adults in changing behaviors and making healthier choices.

Providers will be required to obtain Memorandum of Understanding (MOUs) from Local Mental Health Authority (LMHA), Community Public Health, Office of Border Health, OSARs and DSHS Community Coalition Partnerships in order to facilitate participant referrals and service coordination. This will minimize any duplication of services.

RBI providers will work to engage participants at the local level, integrating and developing support services for individuals experiencing challenges related to substance abuse and use. To enhance the local workforce and effectively reach their target population, RBI providers identify volunteers, Prevention Specialists, and Promotoras (Community Health Worker) within their community to improve health care and access and utilization of needed services. The DSHS will provide certified Promotora hours (CEUs) to individuals who receive training through the DSHS curriculum on behavioral health and behavior change. This DSHS Promotora six-hour curriculum is currently the only state-certified curriculum dedicated to mental health and substance abuse.

The DSHS will participate in national health activities through the DSHS Office of Border Health to promote substance abuse services and awareness in border communities through local, state and federal initiatives. DSHS also anticipates utilizing the Community Health Workers (CHW) curriculum: "Behavior Change with Alcohol and Other Drug Use (AOD) and Mental Health" to train an additional 100 CHWs on the Texas-Mexico border in FY2009.

Universal Indirect Services

Universal indirect services are expected to be provided through 55 programs, including prevention resource centers, community coalitions, prevention media campaign activities, and coordinated prevention training services. These are as follows:

Prevention Resource Centers (PRCs)

In FY09, DSHS will fund eleven Prevention Resource Centers (PRCs), which were selected for awards after the competitive RFP process in FY08. DSHS will fund one PRC in each of the 11 Health and Human Service Commission (HHSC) regions to support information dissemination statewide to schools, communities, prevention providers, churches, professional associations, colleges and universities, and other interested groups throughout the year. The intended target population for each PRC is the residents in their respective HHSC Region which will collectively ensure services to the entire state population.

Each PRC will maintain a web site, a clearinghouse or resource library, and a statewide toll-free number to provide information about prevention. The DSHS website will provide a comprehensive base of information regarding substance abuse including federal, state and local resources, research, media campaigns and information both in English and in Spanish. The PRCs will conduct and

GOAL 2 – 20% For Primary Prevention

annually update the needs assessments for their regions and make it accessible to all service providers and the general population in their communities. They will also coordinate the training services provided with the Prevention Training Services (PTS) contractor and work with the PTS contractor to ensure the service providers in their region informed and participate in the PTS regional training needs assessment. The PRCs will provide tobacco prevention strategies for minors that include community education, retail merchant education, media awareness and tobacco prevention coalition building within a region.

The chart below indicates the anticipated number of activities and persons served by the PRCs in FY 09.

Activity Type	No. of Participants Served or No. of Activities Completed
Number of youth and adults receiving ATOD information	Youth – 527,458 Adults – 197,644
Media Awareness Activities - ATOD	1,279
Tobacco Presentation pertaining to minors and tobacco Youth and Adults attending minors and tobacco presentations	2,203 Youth – 62,164 Adults - 13,892
Media Contacts pertaining to tobacco	653
Tobacco Retailer Compliance Checks	11,660
No. of Written Community Agreements	311

Community Coalitions (CCP)

The DSHS will fund community coalitions selected for awards after the competitive RFP process is completed in FY08. The primary mission of these coalitions is to prevent and reduce the illegal and harmful use of alcohol, tobacco and other drugs in several counties across Texas. The primary emphasis is on the reduction in youth use by promoting and conducting community-based and environmental strategies. In addition, DSHS plans to further implement and encourage the use of the Strategic Prevention Framework (SPF) model for evidence-based practices within community coalitions. This model will require the use of a data-driven decision making and evaluation process. Activities of the CCPs center on the establishing or changing standards, codes, and attitudes within the community. These evidence-based environmental strategies will include assistance to communities in monitoring the enforcement of laws relative to the sale of alcohol and tobacco to minors affecting the promotion and the availability of substances in the community, and affecting social norms and community beliefs about alcohol, tobacco and substance use. Other strategies include the development of comprehensive school policies, providing assistance to schools and community partners and educating policy makers of the needs and gaps in substance abuse services.

Prevention Media Campaign (PMC)

GOAL 2 – 20% For Primary Prevention

The DSHS will continue to fund the PMC media campaign and the Partnership for a Drug Free Texas. In October 2009, the contractor for the PMC will coordinate the annual State Red Ribbon Campaign, which is a model collaborative effort between DSHS, PDFT, National Guard, DEA, HHSC Regional PRCs, and numerous community organizations and private sector entities. The PMC contractor will provide media awareness through radio and TV public service announcements and print ads in local newspapers and materials produced on behalf of PDFT.

Prevention Training Services (PTS)
In 2009, DSHS will continue to contract with a single training entity to coordinate statewide prevention training to include: training on evidence-based curriculum, community mobilization, environmental strategies, and leadership and management development throughout the state. The entity will coordinate with the 11 regional PRCs and Educational Service Centers (ESCs) to provide appropriate regional trainings as determined by the regional provider training needs assessments. The entity subcontracts with the developers of curricula and/or designated Texas trainers to provide local training based on the needs of the universal, selective and indicated populations in Texas, resulting in a more cost effective management of evidence based curriculum training. In FY 2009, the PTS contractor plans to offer over 275 trainings with over 265 participants in coalition training, and over 1,500 youth participants and 1,734 adult participants in topic-specific evidence-based prevention program trainings. The PTS contractor will provide follow-up to youth and adults who received prevention training which will include over 1327 follow-ups with adults and over 1349 follow-ups with youth as well as over 80 follow-ups with adults who participated in the coalition training.

In addition to PTS trainings, DSHS will work collaboratively with other state agencies on the annual Coordinated Prevention Conference such as the Texas Department of Family and Protective Services (DFPS), Office of Attorney General – Juvenile Crime Intervention, and TYC. More than 550 participants are expected to attend as part of a community team at the "Partners in Prevention Training" conference in FY09. The DSHS Annual Summer Institute will provide a comprehensive prevention track, including the basic 40-hour course of preparation for the Certified Prevention Specialist credential, Prevention Ethics, a Coalition Track and a Leadership Management track. In FY 2009, DSHS expects to provide training through this annual Institute to 1400-1500 professionals in the fields of prevention, treatment and mental health, as well as other professionals working in related areas.

The Southwest Center for Application of Prevention Technologies (CAPT) at Norman, Oklahoma will continue to support a Texas state liaison position to provide technical assistance on the Prevention Specialist certification and training module. DSHS will provide office space, equipment, technical support and oversight. The collaborative arrangement is expected to promote workforce development in Texas.

State: Texas

Attachment A: Prevention

Answer the following questions about the current year status of policies, procedures, and legislation in your State. Most of the questions are related to Healthy People 2010 (http://www.healthypeople.gov/) objectives. References to these objectives are provided for each application question. To respond, check the appropriate box or enter numbers on the blanks provided. After you have completed your answers, copy the attachment and submit it with your application.

1. Does your State conduct sobriety checkpoints on major and minor thoroughfares on a periodic basis? (HP 26-25)

○ Yes ◉ No ○ Unknown

2. Does your State conduct or fund prevention/education activities aimed at preschool children? (HP 26-9)

◉ Yes ○ No ○ Unknown

3. Does your State Alcohol and drug agency conduct or fund prevention/education activities in every school district aimed at youth grades K-12? (HP 26-9)

SAPT Block Grant	Other State Funds	Drug Free Schools
○ Yes	○ Yes	○ Yes
◉ No	○ No	◉ No
○ Unknown	◉ Unknown	○ Unknown

4. Does your State have laws making it illegal to consume alcoholic beverages on the campuses of State colleges and universities? (HP 26-11)

○ Yes ◉ No ○ Unknown

5. Does your State conduct prevention/education activities aimed at college students that include: (HP 26-11c)

Education Bureau?	◉ Yes	○ No	○ Unknown
Dissemination of materials?	◉ Yes	○ No	○ Unknown
Media campaigns?	◉ Yes	○ No	○ Unknown
Product pricing strategies?	◉ Yes	○ No	○ Unknown
Policy to limit access?	◉ Yes	○ No	○ Unknown

6. Does your State now have laws that provide for administrative suspension or revocation of drivers' licenses for those determined to have been driving under the influence of intoxication? (HP 26-24)

◉ Yes ○ No ○ Unknown

7. Has the State enacted and enforced new policies in the last year to reduce access to alcoholic beverages by minors such as:

(HP 26-11c, 12, 23)

Restrictions at recreational and entertainment events at which youth made up a majority of participants/consumers:	○ Yes ◉ No ○ Unknown
New product pricing:	○ Yes ○ No ◉ Unknown
New taxes on alcoholic beverages:	○ Yes ◉ No ○ Unknown
New laws or enforcement of penalties and license revocation for sale of alcoholic beverages to minors:	○ Yes ◉ No ○ Unknown
Parental responsibility laws for a child's possession and use of alcoholic beverages:	○ Yes ◉ No ○ Unknown

8. Does your State provide training and assistance activities for parents regarding alcohol, tobacco, and other drug use by minors?

◉ Yes ○ No ○ Unknown

9. What is the average age of first use for the following? (HP 26-9 and 27-4) (if available)

	Age 0 - 5	Age 6 - 11	Age 12 - 14	Age 15 - 18
Cigarettes	○	○	◉	○
Alcohol	○	○	◉	○
Marijuana	○	○	◉	○

10. What is your State's present legal alcohol concentration tolerance level for: (HP 26-25)

Motor vehicle drivers age 21 and older? 0.08
Motor vehicle drivers under age 21? 0

11. How many communities in your State have comprehensive, community-wide coalitions for alcohol and other drug abuse prevention? (HP 26-3)

Communities: 81

12. Has your State enacted statutes to restrict promotion of alcoholic beverages and tobacco that are focused principally on young audiences? (HP 26-11 and 26-16)

◉ Yes ○ No ○ Unknown

Texas
Goal #3: Pregnant Women Services

GOAL # 3. An agreement to expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care (See 42 U.S.C. 300x-22(b)(1)(C) and 45 C.F.R. 96.124(c)(e)).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

GOAL 3 – Pregnant Women Services

Compliance (FY 2006): In FY 2006, DSHS met the expenditure requirements for substance abuse services to pregnant women and women with dependent children, consistent with MOE requirements in statute. The amount of funds expended for services to this target population was $16, 309,049.00 which exceeded the required amount of $13,987,893.00.

In FY 2006, a total of 1,433 pregnant adult women and 56 pregnant adolescent females were admitted to DSHS treatment programs, an increase from the previous year. (1,489 pregnant women were served in treatment programs). Overall, women comprised 45.32% of adult admissions to treatment programs. Pregnant women and women with dependent children accounted for 23.77% of all adult admissions to treatment programs. Residential Specialized Female treatment services (SFS) were available in each of the eleven Health and Human Service Commission (HHSC) regions. There were 22 DSHS SFS treatment programs for women, 15 of which also provided women and children residential services.

DSHS also funded 11 Pregnant and Postpartum Intervention (PPI) programs for priority population women. PPI programs provided outreach, screening and referral to treatment services, education on the effects of Alcohol, Tobacco and Other Drugs (ATOD) on the fetus, case management and parenting education. PPI programs operated in perinatal clinics, Women, Infants and Children (WIC) sites, Department of Family and Protective Services (DFPS) offices, domestic violence shelters, and schools and classrooms for teen mothers.

In FY 2006, all DSHS residential and outpatient SFS programs were required to provide childcare, transportation, gender specific counseling and other specialized services for pregnant and parenting women, including women seeking to regain custody of their children. The programs were also required to coordinate access to pediatric, perinatal and reproductive health care. Specialized female programs were also required to coordinate and integrate services with Workforce Centers, Sexually Transmitted Disease (STD) clinics and perinatal providers. (See Attachment B for a description of specialized services). Service coordination with DFPS continued to be a priority.

In FY 2006, DSHS arranged for in-depth technical assistance from the National Center on Substance Abuse and Child Welfare as part of the Texas Partnership for Family Recovery Initiative (TPFRI) to increase integration and coordination of judicial, legal, child welfare and substance abuse services for families involved with DFPS. The executive team and advisory committee of the TPFRI provided oversight and direction, and developed a guide for communities on how to develop systems of integrated services such as Family Drug Treatment Courts and other strategies.

GOAL 3 – Pregnant Women Services

FY 2008 (Progress): By the end of FY 2008, Department of State Health Services (DSHS) projects total expenditures are estimated to be $19,780,319.00 on treatment services for pregnant women and women with dependent children, again exceeding the required target. To meet the federal requirements for capacity management, establishing new programs or expanding the capacity of existing programs, DSHS continues to fund eleven Pregnant and Postpartum Intervention (PPI) programs. The Request for Proposals (RFP) issued this year will add three additional PPI programs in FY 2009. PPI programs provide outreach, intervention, education and support services in Women, Infant and Children (WIC) sites, alternative high schools, perinatal clinics and Department of Family and Protective Services (DFPS) offices, and coordinate services between delivery systems. PPI services are available in all of the eleven Texas Health and Human Service Commission (HHSC) regions except Region 2.

As of July 2008, Specialized Female Services (SFS) treatment programs, including women and children residential treatment programs, served a total of 7,034 women, of whom 2,363, or 33.6%, were referred by DFPS. SFS programs provide transportation, childcare, referral for pediatric and prenatal care, reproductive health services and gender specific counseling for relationship issues, including issues related to abuse and neglect.

A key strategy for enhancing capacity of treatment services is advancing integrated models of care. In-depth technical assistance from the National Center on Substance Abuse & Child Welfare (NCSACW) on integrated service planning and delivery continued through February, 2008. An interagency effort, the Texas Partnership for Family Recovery Initiative (TPFRI), developed a manual to help communities better integrate judicial, substance abuse and child welfare services, and continues to provide support to communities seeking to improve outcomes for DFPS families. In FY 2008 the Texas Supreme Court took fiscal responsibility for the Texas Court Improvement Project (CIP) funds and established a Commission on Children, Youth and Families. The commission staff sits on the executive and core teams of the Partnership. CIP funds have supported Partnership goals and initiatives through funding of Family Dependency Treatment Courts (FDTC), as well as a retreat to bring together DSHS Outreach, Screening, Assessment and Referral (OSAR) programs with DFPS Substance Abuse Specialists (SAS) and a meeting of 13 judges representing existing and developing FDTCs.

In FY 2008 DSHS contracts with Community Connections from Washington D.C. to provide technical assistance to residential SFS programs to implement trauma-informed management systems. DSHS also provides ongoing clinical fidelity training on *Seeking Safety,* an evidence-based, trauma-informed treatment curriculum.

During FY 2008, an extension of the original Access to Recovery (ATR) Grant continued to make treatment and recovery support services available to all priority population women involved with the DFPS system in the thirteen ATR counties. The second Access to Recovery (ATR II) Grant makes such services available to clients involved with a participating drug court in the 18 ATR counties; including FDTCs. ATR II services are also available to women with a recent history of methamphetamine use. DSHS staff conducted four interactive distance learning classes on women, children and substance abuse for WIC staff. WIC and DSHS staff are planning a pilot project on the prevention of Fetal Alcohol Syndrome Disorder (FASD). The pilot will include co-location of WIC and PPI outreach staff as well as a video dramatization of two birth mothers discussing FASD and the critical important of abstinence during pregnancy.

GOAL 3 – Pregnant Women Services

FY 2009 (Intended Use): In FY 2009, DSHS intends to make funds available at least $19, 780, 319.00 which is consistent with the FY 08 Maintenance of Effort (MOE) spent. These funds will be expended to make services available to pregnant women and women with dependent children. In FY 2009, DSHS projects that, at a minimum, the same number of priority population women will be served as in FY 2008.

In FY 2009, DSHS will issue a substance abuse treatment Request for Proposals (RFP) that will include Specialized Female Services (SFS). The RFP will require SFS residential treatment service providers to use the trauma-informed curriculum, *Seeking Safety*. DSHS will also require programs to continue to implement a trauma-informed management system. In addition, during FY 2009, DSHS will provide on-going training and technical assistance to the current residential SFS programs already using the *Seeking Safety* curriculum and trauma-informed management. DSHS will also provide training and technical assistance for outpatient SFS treatment programs to provide trauma-informed treatment and management.

Continued integration with other state agencies will offer increased opportunities to more comprehensively serve women with substance abuse problems. Several DSHS initiatives, which will continue into FY 2009, will help integrate behavioral and physical health care services for women and children and include the following strategies: service co-location, substance abuse risk assessment, care coordination and sequencing of services for maximum impact. DSHS will review all existing DSHS services for women and children with a goal of establishing unified prevention, intervention and information messages on tobacco, alcohol and other drugs. This will strengthen a project being developed by the DSHS Mental Health and Substance Abuse Division (MHSA) and DSHS Family and Community Health Division's Women, Infants and Children (WIC) program. The project is a pilot program to prevent Fetal Alcohol Syndrome Disorder (FASD). The project will match a PPI program with a WIC site. WIC staff will conduct a brief screening to identify women who may have a substance abuse problem. A PPI outreach worker will then screen for substance abuse service needs. The project will include a video dramatization of two birth mothers discussing FASD and the importance of abstinence from alcohol during pregnancy.

Texas

Attachment B: Programs for Women

Attachment B: Programs for Pregnant Women and Women with Dependent Children (See 42 U.S.C. 300x-22(b); 45 C.F.R. 96.124(c)(3); and 45 C.F.R. 96.122(f)(1)(viii))

For the fiscal year three years prior (FY 2006) to the fiscal year for which the State is applying for funds:

Refer back to your Substance Abuse Entity Inventory (Form 6). Identify those projects serving pregnant women and women with dependent children and the types of services provided in FY 2006. In a narrative of **up to two pages**, describe these funded projects.

ATTACHMENT B: Programs for Women

In FY 2006, DSHS exceeded the required set-aside in block grant funds and state general revenue, with total expenditures of $16,309,049.00 for services to pregnant women and women with dependent children. The base requirement for expenditures for this priority population was $13,987,893.00.

The Substance Abuse Entity Inventory (Form 6) identifies the prevention and treatment programs/providers funded to meet the set-aside requirement for priority population females. In addition to the programs funded through the set-aside, all DSHS treatment programs, except male-only programs, were required to prioritize admission for pregnant women and to ensure, through referral or direct service provision, that pregnant women received prenatal care, information on the effects of alcohol, tobacco and other drugs on the fetus, and referral for HIV information and services. In addition, treatment programs were required to provide childcare while women were receiving treatment services.

All residential and outpatient DSHS SFS programs are required to provide specialized services for pregnant and parenting women, including women seeking to regain custody of their children. These specialized services include targeted outreach; referral, transportation, child development information, and case management and care coordination for all identified service needs. Specific services needs are identified as pediatric, prenatal and reproductive health care; referral and transportation of women and children for immunizations; gender-specific treatment to address relationship issues; parenting education, childcare referral and follow-up for early childhood intervention for children aged 0-3 years; and a strengthening families program for women and their children aged 6-10 years. Programs must also provide capacity management coordination, and when treatment slots were not immediately available, interim services for clients. Interim services include prenatal care, HIV and STD education and referral, and education on the effects of ATOD on the fetus.

The Pregnant and Postpartum Intervention (PPI) programs provide outreach intervention and prevention services in WIC sites, perinatal clinics and CPS offices. PPI programs identify pregnant women at risk for substance abuse and provided screening and referral, education on the effects of ATOD on the fetus, parenting education, alternative activities, home visitation, case management and family support services.

During FY 2006, DSHS contracted for two types of specialized female residential treatment programs (SFS) for pregnant and parenting women: programs for women seeking treatment without accompanying children and women's and children's residential services for women whose dependent children resided with them in the treatment program. Many of the contracted programs offered multiple levels of care and service types. In compliance with DSHS and federal rules, the programs were required to directly provide, or through collaborative agreement, gender-specific services, which included transportation, childcare, parenting education, reproductive health education and care, and counseling for abuse and neglect.

The women and children's residential programs allowed pregnant and parenting women to bring children up to age 12 years into treatment with them, as reflected on Form 6. This modality supported services designed to improve bonding and family relationships. Family services and services for children included parenting assessment, behavioral and physical assessment,

referrals for children, and pediatric referral and care. The length of stay for women's and children's residential programs was generally longer than SFS programs. SFS programs were required to coordinate with Child Protective Services (CPS), Workforce Centers, Early Childhood Intervention (ECI), perinatal and pediatric services, and WIC.

Outpatient programs receiving specialized female set-aside funds were required to provide, or make provisions for, childcare and transportation and were required to provide gender-specific services, including parenting education and counseling for relationship issues. In addition, most residential SFS programs provided outpatient services for continuing care or for women who did not require inpatient care.

During FY 2006, DSHS worked closely with CPS and ECI to facilitate referrals, case coordination and service integration. The MOU between DSHS and DFPS was updated to make all persons involved with the child welfare system a priority population. Referral procedures were standardized and cross training of CPS and substance abuse provider personnel was provided to facilitate implementation. CPS and substance abuse providers were able to access state personnel regarding problems, policy and to facilitate communication between and among the courts, the provider and the child protective services caseworker.

Texas

Attachment B: Programs for Women (contd.)

Title XIX, Part B, Subpart II, ot the PHS Act required the State to expend at least 5 percent of the FY 1993 and FY 1994 block grants to increase (relative to FY 1992 and FY 1993, respectively) the availability of treatment services designed for pregnant women and women with dependent children. In the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for fiscal year 1994.

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section II.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2006 block grant and/or State funds?

3. What special methods did the State use to **monitor** the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

5. What did the State do with FY 2006 Block Grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

ATTACHMENT B: Programs for Women (cont'd.)

1. BG and State GR funded women's programs in FY06 including: capacity, level of care and expenditures

DRAFT: ATTACHMENT B: FY 2006 (BG and GR funded programs/services)							
FY 2006 TABLE OF SPECIALIZED FEMALE PROGRAMS							
Level of Care 1-Intervention 2-WC's 3-SFS 4-Outpatient	Agency	City	Region (substate planning area)	I-SATS ID#	Level of Care (refer to definitions in Section II.4)	Capacity (persons served)	FY06 Expend-itures
1	UT Southwestern Medical Center at Dallas	Dallas	3	N/A	Pregnant, Post-Partum Intervention	138	$383,789
1	Tarrant County Hospital District	Ft. Worth	3	N/A	Pregnant, Post-Partum Intervention	334	$323,187
1	Managed Care Center for Addictive/Other Disorders, Inc.	Lubbock	1	N/A	Pregnant, Post-Partum Intervention	235	$150,554
1	Longview Wellness Center, Inc.	Longview	4	NA	Pregnant, Post-Partum Intervention	1250	$125,071
1	Houston Council on Alcohol and Drug Abuse, Inc.	Houston	6	N/A	Pregnant, Post-Partum Intervention	276	$565,337
1	Aliviane NO-AD, Inc	El Paso	10	N/A	Pregnant, Post-Partum Intervention	112	$95,785
1	Alpha Home, Inc.	San Antonio	8	N/A	Pregnant, Post-Partum Intervention	404	$276,496
1	Central Texas Council on Alcoholism and Drug Abuse	Harker Heights	7	N/A	Pregnant, Post-Partum Intervention	5	$24,413
1	Permian Basin Community Centers for MHMR	Odessa	9	N/A	Pregnant, Post-Partum Intervention	51	$88,918
1	Serving Children and Adolescents In Need, Inc.	Laredo	11	N/A	Pregnant, Post-Partum Intervention	69	$103,846
1	The Council on Alcohol & Drug Abuse – Coastal Bend	Corpus Christi	11	N/A	Pregnant, Post-Partum Intervention	1218	$163,390
2 3 4	Alcohol & Drug Abuse Council for the Concho Valley	San Angelo	9	904007	Women & Children's Residential; Specialized Female Residential; Outpatient	98	$228,672
2 3 4	Aliviane NO-AD, Inc	El Paso	10	300016	Women & Children's Residential; Specialized Female Residential; Outpatient	312	$1,463,453
3 4	Alpha Home, Inc.	San Antonio	8	51259	Specialized Female Residential; Outpatient	293	$614,386
4	Amarillo Council on Alcoholism and Drug Abuse	Amarillo	1	110506	Specialized Female Outpatient	61	$25,211
3 4	Association for the Adv. of Mexican-Americans, Inc.	Edinburg	11	303093	Specialized Female Residential; Outpatient	131	$215,084

ATTACHMENT B: Programs for Women (cont'd.)

2 3 4	Austin Recovery, Inc.	Austin	7	301808	Women & Children's Residential; Specialized Female Residential; Outpatient	291	$942,739
2 3 4	Brazos Valley Council	College Station	7	103105	Specialized Female Residential; Outpatient	135	$132,967
2 3	Coastal Bend Alcohol and Drug Rehabilitation Center: Charlie's Place	Corpus Christi	11	750350	Women & Children's Residential; Specialized Female Residential	58	$432,654
2 3 4	Freeman Center, Inc. The	Waco	7	102867	Women & Children's Residential; Specialized Female Residential; Outpatient	336	$754,213
3 4	Gulf Coast Center	Galveston	6	100671	Specialized Female Residential; Outpatient	293	$310,142
3 4	Managed Care Center for Addictive/Other Disorders, Inc.	Lubbock	1	110241	Specialized Female Residential; Outpatient	358	$581,614
3 4	Mental Health Mental Retardation of Tarrant County	Ft. Worth	3	909675	Specialized Female Residential; Outpatient	724	$577,643
4	Permian Basin Community Centers for MHMR	Odessa	9	302962	Specialized Female Outpatient	149	$146,555
2 3	Nexus Recovery Center	Dallas	3	902647	Women & Children's Residential; Specialized Female Residential	88	$498,413
2 3 4	Patrician Movement, The	San Antonio	8	303366	Women & Children's Residential; Specialized Female Residential; Outpatient	376	$994,422
2 3	Riverside General Hospital	Houston	6	100614	Women & Children's Residential; Specialized Female Residential	193	$680,136
2 3 4	Sabine Valley Center	Longview	4	902563	Women & Children's Residential; Specialized Female Residential; Outpatient	446	$797,348
2 3 4	Santa Maria Hostel, Inc.	Houston	6	106736	Women & Children's Residential; Specialized Female Residential; Outpatient	858	$3,064,925
3 4	Serenity Foundation of Texas	Abilene	2	902811	Specialized Female Residential; Outpatient	285	$398,624
4	Alice Counseling Center	Alice	11	101471	Specialized Female Outpatient	156	$99,657
2 3 4	South East Texas Regional Planning Commission[1]	Lufkin	5	104574	Women & Children's Residential Specialized Female Residential; Outpatient	326	$733,031
2 3 4	Plainview Serenity Center	Plainview	1	905103	Women & Children's Residential; Specialized Female Residential; Outpatient	17	$116,655
4	South Texas Council on Alcohol and Drug Abuse	Laredo	11	109169	Specialized Female Outpatient	303	$417,245
4	Sandstone Health Care	Edinburg	11	001202	Specialized Female Outpatient	132	$137,993

[1] SE Regional Planning Commission is a managed care organization for Region 5.

ATTACHMENT B: Programs for Women (cont'd.)

4	Unlimited Visions Aftercare	Houston	6	113658	Specialized Female Outpatient	30	$32,975
2 3	Volunteers of America Texas Inc	Houston	6	902928	Women & Children's Residential; Specialized Female Residential	299	$877,151
2 3	Volunteers of America Texas Inc	San Antonio	8	902928	Women & Children's Residential; Specialized Female Residential	94	$267,755
2 3 4	Volunteers of America Texas, Inc.	Ft. Worth	3	902928	Women & Children's Residential; Specialized Female Residential; Outpatient	111	$560,444
4	STAR Council on Substance Abuse	Stephenville	2	111504	Specialized Female Outpatient	38	$32,427
4	Star Council on Substance Abuse	Stephenville	3	111504	Specialized Female Outpatient	358	$343,673
2 3 4	TX Dept of MHMR: NorthStar[2]- funded women's services	Dallas	3	301105	Women & Children's Residential; Specialized Female Residential; Outpatient	214	$927,840

#Capacity = total # clients served.

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b) (1) (C) in spending FY 2006 block grant funds and/or State funds?

In FY 2006, DSHS continued to prioritize the use of funds for specialized female services (SFS) programs based on service needs, existing capacity and available funding. DSHS tracked the availability and provision of required specialized female services to ensure that expenditures were for authorized purposes and as required by the set-aside rules for use of block grant funds. Continuous review of utilization rates, program compliance and periodic grant fund analyses were performed to track services provision along with award and expenditure amounts for programs designed for women. All SFS programs were required to provide supportive services that augment treatment and/or contribute to improved treatment and intervention outcomes. The DSHS SFS Coordinator served as an information resource and provided technical assistance to several specialized female services programs.

3. What special methods did the state use to monitor the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

In FY 2006, DSHS required funded providers, through contracts, to comply with all SAPT Block Grant and state rules related to the provision of services for pregnant women and women with dependent children. Along with priority admission for pregnant clients, DSHS required SFS providers to coordinate with Child Protective Services (CPS) and Technical Assistance for Needy Families (TANF) programs, and required all contractors to provide integrated and coordinated family services. SFS providers were also required to refer infants and children aged 0-3 years for early intervention assessment and services. Parents involved with CPS were also made eligible for Access to Recovery (ATR) treatment and support services in the 13 ATR counties.

In addition, revised licensure and contract terms for specialized female and women and children's residential services strengthened on-site care for dependent children. Specifically, facility and service requirements ensured that staff providing daycare completed educational courses in child development and increased standards for meals and physical safety of dependent children, consistent with DFPS licensing standards.

The Behavioral Health Integrated Provider System (BHIPS) database, which provided standardized intake, assessment, treatment planning and service tracking components, was used to monitor the adequacy of efforts by more accurately and comprehensively determining service needs, and service provision and treatment outcomes for priority population women. Data collected through BHIPS were used to identify gaps and begin planning to increase the number of pregnant, post-partum and specialized female treatment programs.

Resource and technical assistance materials were disseminated to SFS providers. The dedicated DSHS SFS Coordinator provided on-site and telephone technical assistance to all SFS programs. The SFS Coordinator also maintains a listserv of managers and clinicians working in PPI or specialized female programs. This allows for immediate dissemination of research materials, evidence based practices, funding announcements and other relevant materials.

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

In FY 2006, provider contracts specified service requirements for pregnant women and women with dependent children. DSHS continued to use data from the client-oriented data acquisition process (CODAP), BHIPS, the statewide drug and alcohol survey, and available prevalence data to estimate treatment needs. Licensure information, billing, and capacity management data were also used to track service gaps and utilization rates. DSHS analyzed treatment admission and discharge data to determine the client population served in relation to the target population and the programs' relative effectiveness in meeting the needs of the population. The BHIPS database continued to be used to access critical information about capacity and service utilization for priority population women.

5. What did the State do with FY 2006 block grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

In FY 2006, DSHS did not issue an RFP for treatment or prevention services. Funds were utilized to maintain the treatment and PPI programs funded in FY05. DSHS staff engaged in numerous interagency planning efforts to increase service integration and coordination with community resources, and to further consolidate interagency coordination efforts with CPS. The DSHS SFS Coordinator participated in a variety of interagency activities to maximize the use of state and block grant funds and to expand the capacity to serve the target population in existing programs through a broader resource base. The Coordinator's interagency activities included being team lead for the Texas Partnership for Family Recovery, coordinating with the Texas Office of Women's Health, WIC, Title IV Maternal and Child Health staff and participating in the Baylor College of Medicine, Texas Women's Health Network. As the lead agency for the Texas

Partnership for Family Recovery Initiative, DSHS brought together the Department of Family and Protective Services (DFPS), Office of Court Administration (OCA), Court Improvement Project (CIP) and Texas Court Appointed Special Advocates (TX CASA) to continue development of a guide on the planning integration and coordination of judicial, legal, child welfare and substance abuse services for families involved with CPS. The guide will be placed on DSHS and other web sites and will be a resource and map for community efforts to develop and implement integrated services to support FDTCs.

Texas
Goal #4: IVDU Services

GOAL # 4. An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. 300x-23 and 45 C.F.R. 96.126).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

GOAL 4 – IVDU Services

FY 2006 (Compliance): Services were made available to IVDUs in all 11 regions of the state, including pharmacotherapy services, residential treatment, residential or ambulatory detoxification and outpatient services. Pharmacotherapy specifically targeted the needs of persons addicted to opiates/narcotics, with the IVDU population as a subset of service recipients accessing opioid replacement therapy services. A total of 75 methadone or other alternative pharmacotherapy programs were available through funded and privately-funded providers throughout all 11 Health and Human Service Commission regions. The block grant funded 15 such opioid replacement therapy programs.

In FY 2006, DSHS monitored IVDU access to all funded substance abuse treatment programs following enhancements to Behavioral Health Integrated Provider System (BHIPS) software that broadened reporting of IVDU activities beyond what was previously captured which was only in pharmacotherapy services. DSHS served 8,560 IVDU clients in all substance abuse treatment-funded venues.

Through BHIPS, DSHS monitored the following activities as part of the capacity management efforts:

(1) the time at which a contractor treating IVDUs reaches 90 percent capacity;
(2) the DSHS program's available bed/slot capacity and remaining funding available;
(3) the length of time an IVDU individual spends on a waiting list; and
(4) if the client received interim or other treatment services while on waiting list for pharmacotherapy services. For example, potential clients could be referred to outpatient treatment, ambulatory detoxification and other individualized services provided by the local community while the client waited for the pharmacotherapy service.

BHIPS enhancements also enabled DSHS to perform timely monitoring of client documentation including admission, discharge planning, problem identification, individual counseling and other activities to verify that quality services were being delivered as efficiently as possible.

HIV outreach programs identified actively-using IVDUs and worked in conjunction with the pharmacotherapy service providers to counsel the client on their risk for communicable disease, encouraging them to maintain their commitment to treatment and make behavior changes. Providers used harm-reduction strategies such as Motivational Interviewing and/or Motivational Enhancement Therapy based upon the client's Prochaska-DiClemente Stage of Change.

GOAL 4 – IVDU Services

FY 2008 (Progress): Capacity reporting among all funded contractors is now monitored daily. Outreach, Screening, Assessment and Referral (OSAR) providers now play a key role in monitoring capacity for residential treatment services by region, with full authority to facilitate admission, using severity guidelines specific to level of care and identification of priority populations at the time of assessment. OSAR sites document waiting list activity and maintain ongoing communication with individuals waiting for treatment. The DSHS HIV outreach programs maintain service agreements with treatment providers and the regional OSARs to ensure that, once identified, an IVDU is prioritized for pharmacotherapy or other residential treatment beds, outpatient treatment slots and/or ambulatory or residential detoxification slots.

In FY 2008, the treatment program that originally began dispensing buprenorphine in FY 07 is continuing that service in FY 08 as another option to addressing the IVDU. The buprenorphine pilot project is the only one of its kind in Texas and is currently located in Austin, Texas at the narcotic treatment program administered through Austin Travis County MHMR. The program now has the slot capacity to serve 30 clients during this period. Outcome data that DSHS has reviewed have been very positive. Data has includes abstinence rates, employment rates and one-year retention rates. These positive outcomes are helping to create opportunities to expand the pilot initiative to additional clients and areas of the state during our next treatment RFP for FY 2010.

GOAL 4 – IVDU Services

FY 2009 (Intended Use): For the coming year, OSAR contract requirements will be implemented to ensure priority populations identified by HIV Outreach programs are moved into treatment slots as quickly as possible and that interim services will be documented for any priority population client awaiting a bed or a treatment slot utilizing OSAR programs or HIV outreach programs. Through the use of BHIPS and the substance abuse quarterly risk assessment tool, services will continue to be reviewed and verified by DSHS to ensure that priority populations are getting optimal opportunity to enter treatment and that interim services are offered in a timely manner. Additionally, DSHS plans to ask for additional dollars in order to replicate and expand buprenorphine pharmacotherapy treatment services to all regions of the state. This will allow more client choice for treatment services.. DSHS will seek replicate this buprenorphine service in all DSHS- funded narcotic treatment programs through the RFP for FY 2010.

The new MIS system known as CMBHS (which will cover both Substance Use Disorder programs and Mental Health programs) will be replacing BHIPS in FY10. Therefore, FY 11 will have additional data regarding IVDU clients and pharmacotherapy programs.

Texas
Attachment C: Programs for IVDU

Attachment C: Programs for Intravenous Drug Users (IVDUs)
(See 42 U.S.C. 300x-23; 45 C.F.R. 96.126; and 45 C.F.R. 96.122(f)(1)(ix))
For the fiscal year three years prior (FY 2006) to the fiscal year for which the State is applying for funds:

1. How did the State define IVDUs in need of treatment services?

2. 42 U.S.C. 300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2006 and include the program's I-SATS ID number (See 45 C.F.R. 96.126(a)).

3. 42 U.S.C. 300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. 96.126(b)).

4. 42 U.S.C. 300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. 96.126(e)).

ATTACHMENT C: Programs for IVDU

1. **How did the State define IVDUs in need of treatment services?**

In FY 2006, DSHS had defined an IVDU as any person who was actively involved in or had a history of injecting illicit or mind-altering substances. The need for treatment services was assessed through a process in which contract staff licensed by the state made a determination for the appropriate level of care. The process included adult and adolescent users, persons in treatment and persons not in treatment, substance users infected with HIV and substance users who were dually diagnosed and part of the mental health care system.

The substance abuse assessment identified individual drug preference, measured severity of addiction, frequency of use and range of motivation. The individual needs of the client are determined and matched with appropriate services through a planning process conducted with the potential client and their family or significant other.

2. **What did the State do to ensure compliance with 42 U.S.C. 300x-22(a)(2) and 300x-23 of the PHS Act as such sections existed after October 1, 1992, in spending FY 2004 SAPT Block Grant funds** *(See 45 C.F.R. 96.124(a)(2) and 96.126(a))?*

In FY 2006, as in previous years, guidelines for Federal SAPT Grant Set-Asides were determined from percentages established by block grant legislation. DSHS Budget Department determined the dollar amounts to fulfill the requirement. It should be noted that DSHS, as a single state agency for substance abuse, did not separate dollars based on amounts expended for treatment, prevention and intervention of alcohol abuse and funds used for "other drugs." All funded providers were required to use funds for all substance abuse activities based upon their ability to do so, and in accordance with administrative rules.

3. **What did the State do to ensure compliance with 42 U.S.C. 300x-31(a)(1)(F) of the PHS Act prohibiting the distribution of sterile needles for injection of any illegal drug** *(See 45 C.F.R. 96.135(a)(6))?*

In FY 2006, DSHS continued to incorporate in each contract issued and each RFP announcement stating that each contract award must comply with all applicable federal and state laws, including 45 CFR 96.135 which prohibited the distribution of sterile needles. In addition, all contract budgets were scrutinized prior being awarded in order to disallow any costs indicating expenses for needle distribution.

Additionally, four trainings were held in January, 2008 on the SAPT Block Grant requirements. Training was held in Austin for the state office staff and four more trainings were held throughout the state for services providers. The training covered the requirement on prohibition of the distribution of sterile needles for injection of any illegal drug.

4. **42 U.S.C. 300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 4444442003**

and include the program's NFR ID number (formerly NDATUS) *(See 45 C.F.R. 96.126(a)).*

DSHS required funded providers to report funded and active bed or program slot capacity and wait list information for each level of care through BHIPS on a daily basis by 11:00 am, Monday through Friday, except for state or federal holidays. In the event that computer problems or other extenuating circumstances prevented the submission of data, the funded provider had to document in writing to DSHS a description of the problem and the data that would otherwise have been reported. Upon the providers' entry of capacity and wait list data into BHIPS, (the system automatically calculated the percentage of each provider's capacity for a particular level of care on a daily basis), an overall report that reflected providers who reported reaching 90 percent of their capacity was generated monthly from the data entered into BHIPS. The following programs, through the use of the Capacity Management Program (CMP), reported they were at 90 percent capacity.

Programs Reporting 90 Percent Capacity for FY 2006

Date	*Facility*	*City*	*Clinic #*
October 05	STARS	Corpus Christi	100622
	TCMERF	Fort Worth	100234
	Austin-Travis County MHMR	Austin	100044
	Center for Health Care Services	San Antonio	100374
	Aliviane NO-AD, Inc.	El Paso	300982
	AAMA	Laredo	110399
	AAMA	Edinburg	112114
	Riverside General Hospital	Houston	116768
	Lubbock Regional MHMR	Lubbock	302822
	Hill Country Community MHMR	Kerrville	101690
	MHMR of Tarrant County	Fort Worth	904353
	Sabine Valley Center	Marshall	001321
	South East Texas Planning Commission	Beaumont	117496
	Gulf Coast Center	Galveston	104533
	Serenity Foundation Of Texas	Abilene	902811
	Homeward Bound	Dallas	103378
November 05	STARS	Corpus Christi	100622
	Riverside General Hospital	Houston	116768
	Austin-Travis County MHMR	Austin	100044
	Center for Health Care Services	San Antonio	100374
	Aliviane NO-AD, Inc.	El Paso	300982
	AAMA	Laredo	110399
	AAMA	Edinburg	112114
	Lubbock Regional MHMR	Lubbock	302822
	TCMERF	Fort Worth	100234
	Gulf Coast Center	Galveston	101673

Date	Facility	City	Clinic #
	Hill Country Community MHMR	Kerrville	101690
	MHMR of Tarrant County	Fort Worth	904353
	Homeward Bound	Dallas	120331
	Sabine Valley Center	Longview	104715
	SE Texas Planning Commission	Beaumont	101690
	Santa Maria Hostel	Houston	102361
	Serving Children and Adol. In Need	Laredo	209876
December 05	AAMA	Laredo	110399
	STARS	Corpus Christi	100622
	Riverside General Hospital	Houston	116768
	Lubbock Regional MHMR	Lubbock	302822
	Austin-Travis County MHMR	Austin	100044
	Center for Health Care Services	San Antonio	100374
	Aliviane NO-AD, Inc.	El Paso	300982
	TCMERF	Fort Worth	100234
	AAMA	Edinburg	110399
	Hill Country Community MHMR	Kerrville	101690
	MHMR of Tarrant County	Fort Worth	904353
	Brazos Valley COADA	Bryan	000721
	Managed Care Center	Lubbock	123111
	Sabine Valley Center	Marshall	001321
	Plainview Serenity Center	Plainview	101767
	SE Regional Planning Commission	Beaumont	101406
	Gulf Coast Center	Galveston	101673
	Odyssey House of Texas	Houston	113583
January 06	Center for Health Services	San Antonio	100374
	Austin-Travis Co. MHMR	Austin	100044
	TCMERF	Fort Worth	100234
	Aliviane NO-AD, Inc.	El Paso	300982
	AAMA	Laredo	110399
	Lubbock Regional MHMR	Lubbock	302822
	AAMA	Edinburg	112114
	STARS	Corpus Christi	001083
	Hill Country Community MHMR	Kerrville	101690
	Managed Care Center	Lubbock	123111
	MHMR of Tarrant County	Fort Worth	904353
	Serenity Foundation of Texas	Abilene	902811
	Homeward Bound, Inc.	Dallas	120331
February 06	Austin-Travis County MHMR	Austin	100044
	Center for Health Care Serci	San Antonio	100374
	Aliviane NO-AD, Inc.	El Paso	300982
	TCMERF	Fort Worth	100234
	AAMA	Laredo	110399

Date	Facility	City	Clinic #
	AAMA	Edinburg	112114
	STARS	Corpus Christi	001083
	Riverside General Hospital	Houston	116768
	Lubbock Regional MHMR	Lubbock	302822
	Gulf Coast Center	Galveston	101673
	Serenity Foundation of Texas	Abilene	
	Managed Care Center	Lubbock	123111
	MHMR of Tarrant County	Fort Worth	904353
March 06	Center for Health Care Services	San Antonio	100374
	Austin-Travis County MHMR	Austin	100044
	TCMERF	Fort Worth	100234
	Aliviane NO-AD, Inc.	El Paso	300982
	AAMA	Laredo	110399
	AAMA	Edinburg	112114
	STARS	Corpus Christi	100622
	Lubbock Regional MHMR	Lubbock	302822
	Riverside General Hospital	Houston	116768
	MHMR of Tarrant County	Fort Worth	904353
	Managed Care Center	Lubbock	123111
	MHMR of Tarrant County	Fort Worth	904353
April 06	Austin- Travis MHMR	Austin	100044
	Center for Health Care Services	San Antonio	100374
	Aliviane NO-AD, Inc.	El Paso	300982
	TCMERF	Fort Worth	100234
	AAMA	Laredo	110399
	AAMA	Edinburg	100168
	Lubbock Regional MHMR	Lubbock	302822
	STARS	Corpus Christi	100622
	Riverside General Hospital	Houston	116768
	Santa Maria Hostel	Houston	106673
	MHMR of Tarrant County	Fort Worth	904353
May 06	Austin-Travis MHMR	Austin	100044
	Center for Health Care Services	San Antonio	100374
	Aliviane NO-AD, Inc.	El Paso	300982
	TCMERF	Fort Worth	100234
	AAMA	Laredo	110399
	AAMA	Edinburg	112114
	STARS	Corpus Christi	100622
	Riverside General Hospital	Houston	116768
	Lubbock Regional MHMR	Lubbock	302822

Date	Facility	City	Clinic #
	Managed Care Center	Lubbock	123111
	MHMR Permian Basin	Midland	000369
	Sabine Valley Center	Marshall	001321
	MHMR of Tarrant County	Fort Worth	904353
June 06	Austin-Travis MHMR	Austin	100044
	Center for Health Care Services	San Antonio	100374
	Aliviane NO-AD, Inc.	El Paso	300982
	TCMERF	Fort Worth	100234
	AAMA	Laredo	110399
	AAMA	Edinburg	112114
	STARS	Corpus Christi	100622
	Riverside General Hospital	Houston	116768
	Lubbock Regional MHMR	Lubbock	302822
	Sabine Valley Center	Marshall	001321
	MHMR of Tarrant County	Fort Worth	904353
	Pan American Community Hospital	El Paso	001304
	MHMR Permian Basin	Midland	000369
	Gulf Coast Center	Galveston	101673
July 06	Austin-Travis MHMR	Austin	100044
	Center for Health Care Services	San Antonio	100374
	Aliviane NO-AD, Inc.	El Paso	300982
	TCMERF	Fort Worth	100234
	AAMA	Laredo	110399
	AAMA	Edinburg	112114
	STARS	Corpus Christi	100622
	Riverside General Hospital	Houston	116768
	Lubbock Regional MHMR	Lubbock	302822
	MHMR of Tarrant County	Fort Worth	904353
	Pan American Community Hospital	El Paso	001304
	MHMR Permian Basin	Midland	000369
	Gulf Coast Center	Galveston	101673
	Patrician Movement	San Antonio	300925
	Managed Care Center	Lubbock	1231111
	Phoenix House of Texas	Dallas	109876
August 06	TCMERF	Fort Worth	100234
	AAMA	Laredo	110399
	AAMA	Edinburg	112114
	STARS	Corpus Christi	100622
	Riverside General Hospital	Houston	116768
	Lubbock Regional MHMR	Lubbock	302822
	MHMR of Tarrant County	Fort Worth	904353

Date	Facility	City	Clinic #
September 06	TCMERF	Fort Worth	100234
	AAMA	Laredo	110399
	AAMA	Edinburg	112114
	STARS	Corpus Christi	100622
	Riverside General Hospital	Houston	116768
	Lubbock Regional MHMR	Lubbock	302822
	MHMR of Tarrant County	Fort Worth	904353
	Pan American Community Hospital	El Paso	001304
	MHMR Permian Basin	Midland	000369
	Gulf Coast Center	Galveston	101673
	Patrician Movement	San Antonio	300925

5. U.S.C. 300x-23(a)(2)(A)(B) of the PHS Act requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days? Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement *(See 45 C.F.R. 96.126(b)).*

In FY 2006, Department of State Health Service's Quality Management Unit conducted an annual administrative, organizational and programmatic site visit on 42 DSHS treatment providers to determine compliance with the 14-120 days timeframe. On-site reviews, internal monitoring and performance reviews of selected treatment providers were conducted using a performance-based risk assessment. The risk assessment used 16 indicators and four clusters. Indicators were based on percentile ranking in a comparison with other providers. The clustering process was used to determine the clinical perspective and practical aspect of each indicator rather than pure statistical procedures. If non-compliance findings were identified, providers were required to submit a plan of improvement. If needed, technical assistance would be provided. The requirement for provision of treatment within 14-120 days of a request for treatment was included as one of the indicators in the risk assessment. Site reviews were conducted based on risk assessment analysis that indicated which providers were the greatest outliers.

6. 42 U.S.C. 300x-23(b) of the PHS Act required any program receiving amounts from the grant to provide treatment for intravenous drug abuse carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished *(See 45 C.F.R. 96.126(e)).*

In FY 2006, DSHS expended $2,638,968 in block grant funds for HIV community-based prevention and intervention services. As defined in DSHS contract terms for funded providers, one of the primary objectives was to educate drug users about harm associated with drug use. HIV risk reduction and community interventionist staff had been thoroughly oriented to models

of persuasion such as Prochaska-DiClemente's Stages of Change and Motivational Interviewing. Using these models as tools, prevention and intervention employees entered areas of the community where injection drug use and HIV were highest. During their outreach efforts, these staff developed rapport and worked with the potential clients in their communities, assessed readiness for treatment and facilitated treatment admission when the clients were ready.

In FY 2006, 21 HIV outreach programs continued to perform intervention activities associated with the CSAP core strategies. These activities included information dissemination, education and skill- building for target populations (including IVDUs and their families), substance abuse screening and referral to treatment and other social services, HIV antibody pre-and post-test counseling, and health screenings for STD, Hepatitis B and C, and TB.

Texas
Attachment D: Program Compliance Monitoring

Attachment D: Program Compliance Monitoring
(See 45 C.F.R. 96.122(f)(3)(vii))

The Interim Final Rule (45 C.F.R. Part 96) requires effective strategies for monitoring programs' compliance with the following sections of Title XIX, Part B, Subpart II of the PHS Act: 42 U.S.C. 300x-23(a); 42 U.S.C. 300x-24(a); and 42 U.S.C. 300x-27(b).

For the fiscal year two years prior (FY 2007) to the fiscal year for which the State is applying for funds:

In **up to three pages** provide the following:

- A description of the strategies developed by the State for monitoring compliance with each of the sections identified below; and
- A description of the problems identified and corrective actions taken:

1. **Notification of Reaching Capacity** 42 U.S.C. 300x-23(a)
(See 45 C.F.R. 96.126(f) and 45 C.F.R. 96.122(f)(3)(vii));
2. **Tuberculosis Services** 42 U.S.C. 300x-24(a)
(See 45 C.F.R. 96.127(b) and 45 C.F.R. 96.122(f)(3)(vii)); and
3. **Treatment Services for Pregnant Women** 42 U.S.C. 300x-27(b)
(See 45 C.F.R. 96.131(f) and 45 C.F.R. 96.122(f)(3)(vii)).

ATTACHMENT D - Program Compliance Monitoring

DSHS developed a performance-based provider selection and monitoring system to provide accountability and improve quality of all funded prevention, intervention and treatment services. This system included quality-based performance standards, and performance-based procurement, review and management strategies. DSHS set standards for prevention and treatment based on research that identifies the most successful models of care and service delivery methods aimed at achieving positive outcomes. Within the DSHS organizational structure, the MHSA Quality Management Unit provided oversight by performing on-site or desk reviews according to a risk-based approach. For substance abuse block grant services, a quarterly risk assessment tool was produced from the data systems to identify providers that were at high risk. Providers that showed to be high risk were scheduled for a programmatic monitoring review. In addition, if any significant program issues arose regarding outcomes in capacity, TB services or services for Pregnant Women, a specific review would be conducted.

Notification of Reaching Capacity

Description of Strategies to Monitor Compliance:
DSHS used various strategies to monitor compliance with capacity reporting requirements in FY2007. A computerized capacity management reporting system was developed in BHIPS, which required each provider of substance abuse treatment services to report capacity on a daily basis.

DSHS used this mechanism to assess all provider treatment capacity for resource allocation and to ensure treatment services were available, first to priority populations, then to all other potential clients who presented themselves for service.

Performance reviews and compliance visits included a review of capacity management utilization and a comparison of capacity data reported with client census records. On-site visits included reviews of documentation related to the provision of interim services for all treatment services, including pregnant females and IV drug users. In addition to waiting list information, providers maintained documentation of interim services to ensure compliance with the interim service requirement for priority populations waiting for services. Additionally, Quality Management staff utilized BHIPS to determine if a provider was documenting these services in the client's record. Finally, staff reviewed information related to methods used by providers to address requests of intravenous substance abusers and pregnant females.

Problems Identified and Corrective Actions Taken:
In FY 2007, providers did not consistently provide notification of reaching capacity. As a result, all funded providers were required to utilize BHIPS, the computerized capacity management reporting system, to report treatment capacity on a daily basis. A report of notification of capacity by providers was generated monthly and DSHS program staff began reviewing data on a routine basis to monitor issues or reporting problems. The monitoring system was designed such that, if a particular provider was having difficulty with reporting on capacity, the provider would receive notification of failure to report capacity and could receive technical assistance as the situation warranted. If non-compliance with reporting capacity information continued, the

provider would be referred to the Contract Oversight Team (COT) process to develop corrective action plans and/or determine appropriate contract action.

Tuberculosis Services

Description of Strategies to Monitor Compliance:
DSHS requires all licensed treatment facilities to offer tuberculosis training to staff and to provide access to tuberculosis services for clients in treatment. DSHS contracts with the Workers Assistance Program to provide training to funded providers on HIV and tuberculosis issues. On-site visits and performance reviews of treatment providers were performed in which DSHS staff verified availability and referral for tuberculosis services by contractors.

Problems Identified and Corrective Actions Taken:
DSHS continues to promote strong relationships between providers and local health departments to ensure that clients in need of HIV and/or tuberculosis case management services are identified and provided access to those services. DSHS continued to sponsor and support training related to linkages and qualified service organization agreements.

DSHS continues to make available the handbook "HIV/AIDS Model Workplace Guidelines for Business, State Agencies, and State Contractors", which was designed to address the process of identifying and screening people at risk of TB as they are being considered for admission to treatment. It recommends a method to develop direct communications with local health departments for quick follow-up. This handbook is located on the DSHS website at the following link: http://www.dshs.state.tx.us/hivstd/policy/pdf/090021.pdf.

Treatment Services for Pregnant Women

Description of Strategies to Monitor Compliance:
DSHS funds and licenses programs, specifically designed for pregnant women and women with dependent children. DSHS rules require that pregnant women not be denied treatment simply on the basis of their pregnancy. They must receive priority admission over other populations, and the availability of services must be adequately publicized.

BHIPS assigns a unique client identifier that tracks the number of pregnant women admitted into treatment across the state, and capacity information is made available to providers through the capacity management program in BHIPS.

DSHS Rule 447 (6)(B) states that interim services shall include counseling and education about HIV and TB, including the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to prevent transmission. Referrals for HIV or tuberculosis treatment shall be provided if necessary. For pregnant females, interim services shall also include counseling about the effects of alcohol and drug use on the fetus and referrals for prenatal care. Rule 447.701 (C) requires that the program maintain documentation of interim services provided. When quality management visits are conducted, a review of the BHIPS waitlist is performed to determine if clients are being placed into treatment according to the priority population. All information pertaining to the waitlist and interim services are

documented on the DSHS compliance waitlist and interim services matrix, which was developed to track provider performance and compliance with a variety of contract requirements.

Problems Identified and Corrective Actions Taken:
Staff continue to provide technical assistance to specialized female services treatment providers to develop and implement outreach strategies and marketing techniques, coordinate efforts with other organizations that serve women and children, and develop strategies to educate the community about substance abuse problems and treatment for women in need of services. In addition, contractual requirements for women and children's programs require additional community collaboration and memorandums of agreement with special health care providers to meet the specific needs of women with children.

In FY 2007, DSHS continued to work closely with other Health and Human Service Commission agencies to implement recommendations regarding staff training and streamlining interagency case coordination. In FY 2008, DSHS planned and hosted a "retreat-style" weekend workshop and invited OSAR program directors as well as key regional DFPS personnel, including the Substance Abuse Specialist for each region. A moderator was hired to handle discussions. The workshop focused on issues between the DSHS funded OSAR and DFPS. The predominant issue related to the fact that DFPS deals with many clients who need, but do not necessarily want treatment and that the OSAR is usually quite overwhelmed with referrals from DFPS. Both "sides" worked together through the weekend to arrive at solutions. The final hours of the workshop were spent with attendees broken out into small groups, by region, to arrive at more concrete solutions.

Texas
Goal #5: TB Services

GOAL # 5. An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

GOAL 5 – TB Services

FY 2006 (Compliance): In FY 2006, DSHS rules for facility licensure required that screening for tuberculosis be made available to all clients that received funded treatment services and that testing be performed as needed. As in previous years, DSHS MHSA's Quality Management Unit monitored for compliance with this rule through review of provider documentation of who had been screened. The DSHS substance abuse rule on this matter states that all persons admitted to treatment or who are on waiting lists to enter treatment be screened for Tuberculosis (TB) unless there is documentation that screening has occurred within the previous year. The vast majority of treatment admissions were provided TB screening services since it is rare that someone presenting for admission comes with documentation of a previous screen that occurred within the specified time frame. DSHS funded treatment providers and HIV providers funded under this grant were given information and training about TB and HIV. During the year, over 600 HIV staff received specific training, a three hour course, "Tuberculosis: What Every Counselor Should Know." These providers offered education about HIV and TB as an interim service for individuals on wait lists for treatment, to clients receiving treatment and as a follow-up service to clients who had been discharged. Two funded HIV programs trained their workers to provide TB testing at the same time they did HIV testing in the community.

Programs were monitored based on a scale related to level of risk. The Quality Management unit verified documentation of TB screens using a sampling method for every program where site visits were performed during FY 2006. Those with larger amounts of funding were monitored more often than those with minimal funding. Those with non-compliance findings in program performance or fiscal accountability were more frequently monitored.

GOAL 5 – TB Services

FY 2008 (Progress): In the current year, over 500 staff in HIV SAMHSA funded providers have received specific training on TB and HIV/AIDS through the HIV Training Services (HTS) contractor. HIV/TB and communicable disease education is offered to all contract program staff at no charge. The curriculum is updated with information that is timely, accurate and appropriate for delivery to all prevention, intervention, and treatment populations. Quality Service Organization Agreements continue to be instrumental in promoting good relations with community and county health department efforts to locate and identify those who may have been exposed to TB while seeking shelter or treatment among individuals at high risk for TB.

Current data from our HIV/STD Epidemiology and Surveillance Branch indicates that there are approximately 1,790 reported AIDS cases with TB in Texas. Texas has also seen a modest reduction in co-morbidity over time, which is most likely attributed to the introduction of antiretroviral drugs and follow-up services.

SAMHSA-funded HIV program providers are required to assist in the provision of interim TB services for all contracted treatment facilities in their catchment areas. DSHS continues to require, through contracts, the provision of TB education, screening and assessment services for individuals on wait lists and for those receiving funded treatment services as defined by Rule 447.701 (B), stated as follows: "Interim services shall include counseling and education about HIV and TB, including the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to prevent transmission. Referrals for HIV or tuberculosis treatment are provided, if necessary. For pregnant females, interim services shall also include counseling about the effects of alcohol and drug use on the fetus and referrals for prenatal care."

Documentation of client schedules and participation for all activities performed while clients participate in treatment is required by contract, including education and counseling activities associated with TB, HIV and other communicable diseases. Interim services are also documented for clients on waiting lists for treatment. All such documentation (client schedules and interim services) are monitored by the Quality Management unit during site visits to ensure program requirements are met.

GOAL 5 – TB Services

FY 2009 (Intended Use): DSHS Communicable Disease Control indicates that our federal funds will continue to support public health intervention activities such as Directly Observed Therapy (DOT), contact elicitation, outbreak and contract investigations. TB screenings which occur during an investigation or through correctional facilities that meet Texas Health and Safety Code Chapter 89 requirements will continue to be funded by the Texas General Revenue and CDC. SAMHSA funded HIV providers and treatment providers will continue to work closely with the Communicable Disease staff and providers. DSHS will continue to build relationships between treatment providers, local health departments and DSHS HIV programs to ensure that persons in need of substance abuse treatment and HIV and/or tuberculosis services (and Hepatitis) are identified through the screening and assessment process and provided access to those services.

DSHS will continue to sponsor and support training and technical assistance (TA) that includes how to establish and maintain linkages through Qualified Service Organization Agreements (QSOAs) and how to enhance availability and efficiency of service provision. DSHS Training for TB, HIV, hepatitis and other communicable diseases will continue to be coordinated through the HTS. We anticipate that over 600 HIV providers will receive specific training on HIV and TB over the year from the HTS contractor. That contractor also has items such as QSOAs and other administrative matters addressed as appropriate within the framework of their numerous curricula. DSHS staff and subject matter experts will review and approve each curriculum, checking for accuracy and fidelity of materials and quality of presentation. Each quarter, DSHS staff will review training evaluations from each training event held by the HTS to ensure fidelity and accuracy of the material presented.

Texas
Goal #6: HIV Services

GOAL # 6. An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. 300x-24(b) and 45 C.F.R. 96.128).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

GOAL 6 – HIV Services

FY 2006 (Compliance): In FY 2006, a network of HIV early intervention services was maintained with block grant funds to ensure a service system that would target substance abusers at risk for and infected with HIV, and would promote communicable diseases education and training for those at risk, their families and significant others. The HIV program network was comprised of 31 HIV prevention and intervention programs, including testing, risk reduction, and case management programs; one training program the HIV training services (HTS) which promotes communicable disease education and training; and one HIV residential treatment program, which is not funded with set-aside funds. HIV programs funded with HIV set aside funds were in nine of the 11 regions of the state, and provided critical services in sub-state planning areas that were most in need of HIV early intervention services, which included regions 1, 3, 4, 5, 6, 7, 8, 10 and 11.

HIV intervention and risk reduction programs were responsible for targeting active users at highest risk of infection and performing the first line of intervention for promoting behavior change, using Motivational Interviewing techniques and the Transtheoretical Model, Prochaska-DiClemente Stages of Change. They also performed the largest portion of the HIV counseling and testing effort, locating and identifying HIV-infected, chemically-dependent persons (as well as those identified at risk) encouraging them to enroll in HIV early intervention case management and substance abuse treatment services. In FY 2006, HIV Outreach programs contacted 107,566 (adults and youth) at risk for HIV and other communicable diseases. HIV early intervention programs performed case management for an ongoing caseload of HIV-infected, chemically-dependent individuals. The program's purpose was to ensure that adequate resources were dedicated to services related to HIV disease management and to address substance abuse treatment and recovery simultaneously.

HIV early intervention case management programs also reduced barriers to treatment access by serving as the gate for admission to Homeward Bound, the HIV residential treatment program, providing treatment services to HIV-infected persons in need of and ready for substance abuse treatment. (NOTE: The treatment program portion of the network was funded separately and was not considered a part of the HIV set-aside). HIV intervention, risk reduction and early intervention programs provided the largest portion of interim services for all the treatment providers in their region. Block grant funds also supported education and training through the HTS contractor to ensure that all HIV contract staff and all funded treatment and prevention programs were kept current on the latest HIV clinical information and trained on the National Institute on Drug Abuse's Community-based Outreach Model, Motivational Interviewing and the Transtheoretical Model of Change/Prochaska-DiClemente's Stages of Change.

FY 2006 also marked the first full year of rapid testing throughout the Texas SAMHSA funded HIV programs. The SAMHSA Rapid Testing Initiative of 2005 continued to be useful in providing additional resources to contractors throughout the state. Many of our contractors began a "marketing" campaign in their communities to increase testing of at- risk populations through rapid testing. Twenty new cases were identified by one of the Houston area (Region 6) contractors during this time. All tests were confirmed using the OraQuick processes and were reported using the state data collection system. The positivity rate for rapid testing services continued to mirror the national average.

GOAL 6 – HIV Services

HIV programmatic and fiscal activities were monitored by comparing monthly and quarterly reports against performance measure projections submitted by providers and by using matrices built by DSHS staff specific to each program type. These tools were used to monitor ability to provide interim services to IVDU clients waiting for treatment, performance measure documentation, service agreements that link provider resources, etc.

GOAL 6 – HIV Services

FY 2008 (Progress): This was the last year of contract renewals and DSHS followed a new solicitation process of procurement for all its HIV intervention programs and SA prevention programs under SAMHSA's block grant. The new RFP solicitation process was designed to focus HIV early intervention services in the regions of the state that have growing numbers of HIV/AIDS cases, increased risk, and/or drug use. Nine of eleven regions in the state were eligible to apply for these five year (annual renewal) grants. Applicants were asked to respond to the RFP which targeted the following: (1) Persons at risk of being infected with HIV as a result of practicing behaviors related to a substance abuse lifestyle (2) Persons who are HIV infected and identified as having a problem with substance abuse (3) Significant others and/or family members of those described in #1 and #2.

Currently there are 32 SAMHSA HIV funded block grant programs. HIV early intervention case management programs currently serve an average of 900-1300 HIV-infected, chemically-dependent individuals on the caseloads. That number has been relatively constant for the past five years. HIV testing, intervention and risk reduction activities account for approximately 85,000 contacts for the year based on numbers reported during the first, second and third quarters of FY 08

The State of Texas HIV program effort has suffered a slight decrease in funding from CDC (prevention) and HRSA/Ryan White (HIV clinical services). Both DSHS HIV/STD and DSHS HIV/SA divisions continue to actively collaborate and examine how to best leverage services to the target population.

While this year marked a transition in program coordination at the DSHS staff level, there was a strong plan in place to provide programmatic continuity. Key Performance Measures continue to be reviewed in order to capture clear numbers and information that would allow for improved program evaluation and quality improvements. We continue to monitor these measures quarterly and provide technical assistance to all contractors in how to best report their accomplishments and the changing trends/needs of our target populations across the state.

While the SAMHSA Rapid Test Initiative ended and all the kits were distributed, DSHS HIV programs continued to rely on the Rapid Test as the primary tool for counseling and testing high-risk populations. Counseling and testing (not screening) continued to be the strategy for performing HIV testing within SAMHSA/DSHS HIV programs. All HIV testing contractors were required to use Rapid Test devices for at least 40% of all HIV testing performed. Contractors continued to be convinced of its usefulness, most used Rapid Tests 90% of the time, holding to blood draws only when requested or when working with less transient populations. The latest information on "false positives" released by the New York City Health Dept. and the CDC was received and a review by this office and our HIV testing providers, began in order to determine what changes may be needed in our rapid testing protocols. Currently, all providers are reporting their false positive tests/numbers to this office by telephone calls to the HIV Coordinator and are following procedures for confirmatory testing

DSHS was also successful in initiating a plan to increase unit costs for HIV residential treatment and thereby improve quality of service. The approved rate went from a $69.00 unit cost for an HIV substance abuse treatment bed to $108.00 this year.

GOAL 6 – HIV Services

HIV early intervention program services continue to be monitored through a matrix developed by the Program Implementation and Quality Management units of MHSA. This matrix is used during site visits to determine that all documentation related to required services associated with HIV early intervention program activity is accurate and timely. In addition, HIV early intervention programs continue to report quarterly through BHIPS on level of access to services associated with case management. For example, one key measure evaluates how many clients in the HIV case management caseload are engaged in substance abuse services. Note: A client receiving these case management services may participate in program activities regardless of whether he/she is also in substance abuse treatment. Since the program strives to address HIV clinical issues and recovery simultaneously, this measure is used as an indicator for success in persuasion and engagement techniques used for meeting that goal, how the program employs best practice skills such as those associated with motivational interviewing, and other client-centered counseling strategies.

GOAL 6 – HIV Services

***FY 2009 (Intended* Use):** HIV programs will continue to rely on the Rapid Test as the primary tool for counseling and testing high-risk populations. DSHS will continue to work with SAMHSA funded contractors to monitor and obtain the latest research and information available through the CDC and SAMHSA regarding false positivity rates with Rapid Testing. DSHS will work with contractors to develop a monitoring system so that contractors will report any false positives on an ongoing basis directly to DSHS in addition to following other established reporting protocols. In addition, we will work closely with contractors to follow all CDC and SAMHSA recommendations and possible changes in protocols. Counseling and testing (not screening) will continue to be the strategy for performing HIV testing within SAMHSA/DSHS HIV programs. If funding continues as expected, the HIV program network will continue with all program types as described, with expectations of incorporating new strategies to influence pharmacotherapy populations.

New contract awards for this new cycle will require additional monitoring, training (through the HIV Training Services (HTS) contract) and technical assistance follow-up. Progress with Performance Measures will be monitored monthly through BHIPS and through quarterly reports from the contractors. Over this next year DSHS will work closely with contractors to determine to best and clearest Key Performance Measures that provide the most accurate and useful information for program design and monitoring. HIV early intervention case management services will be new to two providers (Region 6 and Region 11) this year and one provider (Region 4) has been contracted to provide additional HIV early intervention services which include testing, risk reduction and intervention beginning this year. A total of 28 SAMHSA HIV early intervention programs will be serving Texans this year.

The Ryan White AIDS Drug Assistance Program (ADAP) program funding with DSHS is expected to meet the demands of projected eligible cases. Since all HIV clients receiving case management meet the eligibility requirements for receiving those medications there should be no gaps related to securing HIV antiretroviral treatment. .

New joint collaboration planning meetings between the DSHS HIV/STD division and the DSHS HIV/MHSA division will begin this year for the purpose of determining the feasibility of testing and actively supporting both Hepatitis and HIV testing in all treatment facilities/programs for all clients. This is both a public health and substance abuse treatment issue which will require a strong integrated approach with clear protocols and clear communication with clients. In addition, we anticipate a stronger collaboration will assist in developing a higher level of resource mapping (HIV) for the state and a more timely approach to dealing with changing drug use patterns and new HIV cases.

DSHS will also continue to closely monitor changes in drug use patterns across the state, especially in the Texas-Mexico Border regions. Working closely with SAMHSA and the Gulf Coast Addiction Technology Transfer Center researchers will allow us to further monitor the use of injection and non injection drugs which are increasingly impacting high risk sexual activity and risk for HIV/AIDS.

All DSHS HIV program services will continue to be monitored onsite using the program matrix developed by Program Implementation and Quality Management units. In-house desk reviews will be performed by DSHS staff, using monthly and quarterly reviews as submitted quarterly in BHIPS.

Texas

Attachment E: TB and Early Intervention Svcs for HIV

Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV (See 45 C.F.R. 96.122(f)(1)(x))
For the fiscal year three years prior (FY 2006) to the fiscal year for which the State is applying for funds:
Provide a description of the State's procedures and activities and the total funds expended (or obligated if expenditure data is not available) for tuberculosis services. If a "designated State," provide funds expended (or obligated), for early intervention services for HIV.

Examples of procedures include, but are not limited to:

• development of procedures (and any subsequent amendments), for tuberculosis services and, if a designated State, early intervention services for HIV, e.g., Qualified Services Organization Agreements (QSOA) and Memoranda of Understanding (MOU) ;
• the role of the single State authority (SSA) for substance abuse prevention and treatment; and
• the role of the single State authority for public health and communicable diseases.

Examples of **activities** include, but are not limited to:
• the type and amount of training made available to providers to ensure that tuberculosis services are routinely made available to each individual receiving treatment for substance abuse ;
• the number and geographic locations (include sub-State planning area) of projects delivering early intervention services for HIV ;
• the linkages between IVDU outreach (See 42 U.S.C. 300x-23(b) and 45 C.F.R. 96.126(e)) and the projects delivering early intervention services for HIV; and
• technical assistance.

ATTACHMENT E: TB and Early Intervention Services

Procedures

FY 2006 marked the second full year of the consolidation of the state's substance abuse prevention and treatment, mental health and public health agencies into DSHS. This consolidation provided for increased opportunities to maximize funding and integrate resources across divisions within one agency, as opposed to the challenges associated with leveraging resources across separate and independent agencies. Through the consolidation, strategies targeting public health and prevention of communicable diseases became better aligned and linked with substance abuse treatment and early intervention strategies.

In FY 2006, DSHS's Prevention and Preparedness Services Division, responsible for preventing and addressing communicable diseases, continued funding and support to the block grant funded substance abuse treatment programs to work with local health departments and DSHS substance abuse HIV outreach programs to provide TB screening, medical examinations and instruction for appropriate self-care medications for all clients in substance abuse treatment. DSHS rules for substance abuse contractors required service agreements be initiated and maintained between local health departments and funded HIV and HEI program providers to identify and treat persons exposed to or infected with TB.

All HIV early intervention programs are under program requirement to initiate and maintain specific service agreements (QSOAs) between their individual organization and all social service agencies, substance abuse treatment organizations and other community organizations with an interest in providing services or benefit to the target population. Local health departments and licensed and funded substance abuse treatment programs are included in this requirement. Compliance is monitored during Quality Management site visits. Quality Management checks to make sure these service agreements are updated annually and specifically describe services provided by that organization. That includes provision of interim services and facilitation of TB, HIV and other screenings or tests for communicable disease for clients of funded treatment providers.

The amount of state funding for TB services targeting persons receiving treatment for substance abuse, administered by DSHS's Prevention and Preparedness Services Division, was estimated to be $2,666,243.00 or approximately 24% of funds designated for TB screening and services to the population at large.

Activities

In FY 2006, access to TB screening was and continues to be a licensure requirement for all substance abuse treatment program providers. Rules ensured that every client admitted to treatment was screened unless a recent previous test with a negative result could be verified within the prior year. TB education for contracted staff was part of an ongoing training curriculum offered at no cost to all funded providers

Specific TB information is provided in two separate curricula - "Tuberculosis 101, Cause, Detection, and Prevention," (a six hour course) and, "Tuberculosis: What Every Counselor Should Know" (a three hour course). These curricula are available from HTS contractor.

ATTACHMENT E: TB and Early Intervention Services

Training on TB is provided upon request and at no cost to all block grant funded treatment, intervention and prevention program providers.

All HIV early intervention programs shared responsibility for providing interim services, including education about TB, HIV and other communicable diseases for all persons on waiting lists for substance abuse treatment whenever it is requested by the treatment provider. In FY 2006, there were 22 organizations providing HIV risk reduction, intervention, case management services under the SAMHSA funded HIV early intervention programming, in addition to required interim services. Those were on call and available to offer interim services to all IVDUs and other substance abusers on waiting lists for treatment providers in Regions 1, 3, 4, 5, 6, 7, 8, 10 and 11. The education presentations or counseling sessions included information about communicable diseases and risks associated with drug and alcohol use. They offered access to testing and screening for HIV, TB, and STDs in accordance with agreements established between the HIV service provider and the treatment program.

Early Intervention Services for HIV

In FY 2006, a network of HIV early intervention services was maintained through block grant funds to ensure a service system that would target substance abusers at risk for and infected with HIV. The HIV program network was comprised of 31 HIV risk reduction, community based interventions and early intervention case management programs); one training program (HIV training services or HTS), which promotes communicable disease education and training; and one HIV residential treatment program. A total of $6,774,380.00 was expended in block grant funds on early intervention services for HIV, consistent with the 5% set-aside requirement established in the summer of 2002. An additional amount of $403,503.00 was expended in state general revenue funds, consistent with the mandatory five percent cap. A combination of block grant set-aside funds and state general revenue supported all the programs within the HIV network with the exception of the HIV residential treatment program which is funded with block grant treatment funds.

In FY 2006, early intervention programming comprised a number of strategies designed to intervene with persons actively involved in risk behaviors associated with HIV and other communicable diseases. HIV early intervention programs were located in nine of the 11 Health and Human Service Commission regions of Texas with multiple programs installed in all major metropolitan areas with high rates of HIV/AIDS, (Houston, Dallas, Ft. Worth, San Antonio, Austin) including high risk areas such as, South Texas (Laredo, McAllen, Brownsville, and Harlingen), and other risk areas such as Galveston and Beaumont. One training program, HTS, continued as the primary capacity building agent in the network. They offered over 10 different curricula to contractors in order to build motivational interviewing skills, counseling skills and support behavior change efforts and procedures [using the model established by the National Institute on Drug Abuse (NIDA)], ensuring that all HIV community based programs operate in a safe manner. In FY 2006, the HTS facilitated education about HIV, TB, hepatitis and other communicable diseases for all block grant funded treatment, intervention and prevention programs, Over 700 participants were trained through their HIV/AIDS Update and TB courses.

FY 2006 marked the first full fiscal year of the HIV Rapid Test Initiative which began in June 2005 in Texas. All program staff that performed counseling and testing through this initiative

was thoroughly trained in laboratory procedures, interpreting preliminary test results and reporting outcomes. Participants who were identified and confirmed as positive were offered immediate intervention services including case management, access to an HIV-knowledgeable primary care physician and opportunities to enter substance abuse treatment and recovery.

Texas

Goal #7: Development of Group Homes

GOAL # 7. An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. 300x-25). Effective FY 2001, the States may choose to maintain such a fund. If a State chooses to participate, reporting is required.

FY 2006 (Compliance): (Reporting REQUIRED if State chose to participate)
FY 2008 (Progress): (Reporting REQUIRED if State chose to participate)
FY 2009 (Intended Use): (State participation is OPTIONAL)

FY 2006 (COMPLIANCE)

N/A

FY 2008 (PROGRESS)

N/A

FY 2009 (INTENDED)

N/A

Texas
Attachment F: Group Home Entities

Attachment F: Group Home Entities and Programs
(See 42 U.S.C. 300x-25)

If the State has chosen in Fiscal Year 2006 to participate and continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund then Attachment F must be completed.

Provide a list of all entities that have received loans from the revolving fund during FY 2006 to establish group homes for recovering substance abusers. In a narrative of **up to two pages**, describe the following:
- the number and amount of loans made available during the applicable fiscal years;
- the amount available in the fund throughout the fiscal year ;
- the source of funds used to establish and maintain the revolving fund ;
- the loan requirements, application procedures, the number of loans made, the number of repayments, and any repayment problems encountered ;
- the private, nonprofit entity selected to manage the fund ;
- any written agreement that may exist between the State and the managing entity ;
- how the State monitors fund and loan operations ; and
- any changes from previous years' operations.

N/A

Texas
Goal #8: Tobacco Products

GOAL # 8.

An agreement to continue to have in effect a State law that makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18; and, to enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18 (See 42 U.S.C. 300x-26, 45 C.F.R. 96.130 and 45 C.F.R. 96.122(d)).

- Is the State's FY 2009 Annual Synar Report included with the FY 2009 uniform application? (Yes/No)

- If No, please indicate when the State plans to submit the report: (mm/dd/2008)

Note: The statutory due date is December 31, 2008.

Yes. The Texas FY2009 Annual Synar Report is included with the FY2009 uniform application.

Texas

Goal #9: Pregnant Women Preferences

GOAL # 9. An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. 300x-27 and 45 C.F.R. 96.131).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

GOAL 9 – Pregnant Women Preferences

FY 2006 (Compliance): In FY 2006, to facilitate priority treatment access and referrals for pregnant women, Department of State Health Services (DSHS)-funded service providers were required to report daily capacity for treatment through the Behavioral Health Integrated Provider System (BHIPS) Capacity Management Program (CMP), an automated statewide reporting system. The CMP provided information on all available treatment slots including those designated for Specialized Female Services (SFS). The Program Implementation Unit of the DSHS-Community Mental Health and Substance Abuse (MHSA) Services Division managed and closely monitored the CMP for compliance, accuracy and timeliness of reporting. The CMP greatly improved both access to treatment and data on availability of treatment slots. For pregnant women, the contracts continued to require:

- DSHS treatment providers submit updated daily capacity information by 11 a.m. The information provided included number of available residential, outpatient and methadone slots and waitlist information.
- If a program was unable to admit a pregnant woman due to insufficient capacity, providers were required to call the CMP's toll-free number for statewide capacity information.

All substance abuse treatment programs receiving SAPT Block Grant funds were required to provide treatment on demand for pregnant substance abusing females who presented for treatment. If the program did not have capacity, DSHS required the facility to access the CMP to identify other treatment resources.

In the event that no DSHS provider had the capacity to admit a pregnant female into treatment, the provider that screened the woman was required to make interim services available within 48 hours from the time she sought treatment. These services included, but were not limited to, information on the effects of alcohol, tobacco and other drugs on the fetus, communicable disease information, education, intervention and perinatal service access. Pregnant opiate drug users were referred to methadone treatment programs where they were given priority admission status.

DSHS SFS residential and women and children residential treatment programs were required to publicize the availability of services for pregnant substance abusing women and to inform relevant entities in their communities that such treatment was available. Relevant entities included health clinics providing prenatal care, emergency treatment facilities, hospital obstetrical units, local Department of Family and Protective Services (DFPS) offices and street outreach programs.

In FY 2006, to facilitate service improvement and access, DSHS and DFPS continued to collaborate through their work with the Texas Partnership for Family Recovery (the Partnership) to integrate judicial, legal, child welfare and substance abuse services for families. The Partnership received in-depth technical assistance from the National Center on Substance Abuse and Child Welfare. DFPS clients were eligible for Access to Recovery (ATR) services in the 13 participating Texas counties.

GOAL 9 – Pregnant Women Preferences

FY 2008 (Progress): During FY 2008, an extension of the original Access to Recovery (ATR) Grant continued to make treatment and recovery support services available to all priority population women involved with the Department of Family and Protective Services (DFPS) in the thirteen ATR counties. The second Access to Recovery (ATR II) Grant makes such services available to clients involved with a participating drug court, including Family Dependency Treatment Courts (FDTC) in the eighteen ATR counties. The program provides support services in addition to substance abuse treatment, and increases opportunities for access to services for pregnant women and women with dependent children. ATR programs are managed by DSHS funded Outreach, Screening, Assessment and Referral (OSAR) programs. OSAR staff assigned to ATR services work closely with existing and developing FDTCs. A total of 16 counties have participating courts.

The Texas Partnership for Family Recovery (the Partnership), an interagency initiative led by DSHS in partnership with the DFPS, the Office of Court Administration (OCA), Texas Court Appointed Special Advocates for Children (TX CASA) and the new Supreme Court Commission on Children, Youth and Families, utilized Court Improvement Project (CIP) funds to establish a FDTC in Tarrant County. CIP funds also were used to hold a two-day retreat with DSHS, OSAR and DFPS Substance Abuse Specialists (SAS) to reduce barriers in referral to and care coordination of services for perinatal women involved with DFPS. CIP funds were also used to conduct a meeting with 13 judges representing existing and planned FDTCs. The National Center for Substance Abuse and Child Welfare (NCSACW) facilitated the discussion which focused on identifying substance abuse service needs and barriers to service. Partnership core team members followed up on this meeting through site visits to all of the courts to review policies and procedures and facilitate service coordination. DFPS also introduced a unique client identifier number into their data base to allow tracking of parents involved with FDTCs. The goal is to measure impact and outcomes of FDTCs.

In FY 2008, DSHS continues to analyze service utilization and demand to identify gaps in service and to refine a statewide delivery system based on regional and sub-regional referral and access trends. DSHS continues funding for eleven Pregnant and Postpartum Intervention (PPI) programs. PPI programs coordinate referrals with DSHS treatment providers to facilitate access to treatment for pregnant substance abusing women. The FY 2008 DSHS Prevention and Intervention Request for Proposals (RFP) includes PPI services. A total of 14 programs will be funded as of FY 2009.

GOAL 9 – Pregnant Women Preferences

FY 2009 (Intended Use): In FY 2009, the Capacity Management Program (CMP) will continue to provide an automated system to monitor available slots in DSHS funded treatment programs that serve pregnant women and women with dependent children. DSHS staff will continue to monitor the data to ensure that capacity information is accurate and timely, and that appropriate services are available to pregnant women. BHIPS will also provide detailed data on priority population females including clinical profiles, needs and service use trends. Through ongoing review of utilization and capacity data, DSHS will continue to provide leadership for interagency efforts to ensure that treatment services for pregnant women are provided in a timely, effective and efficient manner. All programs will continue to be required to submit a daily capacity report. DSHS staff and Outreach, Screening, Assessment and Referral (OSAR) programs will use CMP data to access available bed space for priority admissions. The new Clinical Management for Behavioral Health Services (CMBHS) electronic record system will improve DSHS's ability to track the number of women and their children in treatment as well as the additional services provided during an episode of care.

In FY 2009, DSHS will fund three additional Pregnant and Postpartum Intervention (PPI) programs. The PPI programs provide outreach, intervention, screening and referral for perinatal women at risk for substance abuse. Staff members are located in Women, Infant and Children (WIC) sites, perinatal clinics, Department of Family and Protective Services (DFPS) offices and similar sites. Staff facilitate early identification and access to substance abuse services. The goals are to improve birth outcomes, improve parenting skills and support mother-child bonding.

During FY 2009, DSHS will continue technical assistance to Specialized Female Services (SFS) residential treatment programs to support *Seeking Safety,* an evidence-based trauma-informed treatment curriculum. The agencies will also continue to receive technical assistance in developing trauma informed management systems. This technical assistance will enhance the impact of the Texas Partnership for Family Recovery's integration of judicial, child protective services and substance abuse treatment programs and support the development of Family Dependency Treatment Courts. The service integration will improve access to services and the engagement and retention of pregnant and postpartum women in treatment.

DSHS will continue to monitor compliance with licensure requirements and rules specific to priority admission for pregnant women and women with dependent children. DSHS will also continue to provide technical assistance to develop a seamless continuum of care and ensure priority access to services for pregnant women and women with dependent children. DSHS will continue to participate in a range of collaborative interagency efforts.

Texas
Attachment G: Capacity Management

Attachment G: Capacity Management and Waiting List Systems
(See 45 C.F.R. 96.122(f)(3)(vi))
For the fiscal year two years prior (FY 2007) to the fiscal year for which the State is applying for funds:
In **up to five pages**, provide a description of the State's procedures and activities undertaken, and the total amount of funds expended (or obligated if expenditure data is not available), to comply with the requirement to develop capacity management and waiting list systems for intravenous drug users and pregnant women (See 45 C.F.R. 96.126(c) and 45 C.F.R. 96.131(c), respectively). This report should include information regarding the utilization of these systems. Examples of **procedures** may include, but not be limited to:

- development of procedures (and any subsequent amendments) to reasonably implement a capacity management and waiting list system ;
- the role of the Single State Authority (SSA) for substance abuse prevention and treatment ;
- the role of intermediaries (county or regional entity), if applicable, and substance abuse treatment providers; and
- the use of technology, e.g., toll-free telephone numbers, automated reporting systems, etc.

Examples of **activities** may include, but not be limited to:

- how interim services are made available to individuals awaiting admission to treatment ;
- the mechanism(s) utilized by programs for maintaining contact with individuals awaiting admission to treatment; and
- technical assistance.

ATTACHMENT G: Capacity Management

In FY 2007, a total of $14,496.00 was expended to comply with the requirement to develop capacity management and waiting list systems for intravenous drug users and pregnant women, consistent with 45 C.F.R. 96.126 (c) and 45 C.F.R. 96.131 (c) respectively.

In FY 2007, the data entry screen in BHIPS provided access to the Available Capacity System, which allowed DSHS to monitor beds available in state-funded treatment programs, including methadone programs.

DSHS staff monitored the Capacity Management System through the BHIPS automated system daily to ensure that providers were in compliance with capacity management reporting requirements in BHIPS in a timely manner, and appropriate service levels were accessed by priority population clients. Using information from the BHIPS entry screens and internal reports, DSHS staff identified providers who did not use BHIPS and provided technical assistance by phone to providers that did not report, and to providers who requested assistance in finding available treatment capacity for priority populations (pregnant females and IV drug users).

Treatment providers had a contractual requirement to report Daily Available Capacity information by 11 a.m. Providers that adequately explained days of non-compliant reporting were excused for those days. When there was a pattern or trend toward late reporting or non-reporting in a given month, the provider received a "non-compliant" rating for that month. A non-compliant month of available capacity reporting was treated like a late fiscal report when consideration was given to historical performance for future funding. The reporting system provided data to help DSHS analyze utilization of resources. Weekly monitoring in BHIPS by the DSHS Capacity Management Coordinator ensured that capacity information was being submitted in a timely manner. The Capacity Management Coordinator notified providers weekly by e-mail when a pattern of late reporting or non-reporting was identified.

Treatment providers used the online function to search for available capacity by county or by provider name. The system allowed providers with priority population clients on their waiting list to search for treatment programs that had available beds. Online instructions directed providers to contact DSHS staff for assistance in placing clients into treatment or interim services. The wait list information in the BHIPS system gave step-by-step instructions on how to maintain the wait list. Providers who were at maximum capacity placed clients needing treatment services on the wait list for the specific service type that addressed the client's problem with the highest severity. Interim services were provided until needed services became available, and clients in the priority population that had been on the wait list the longest were admitted first. The new reports developed in December 2006 to monitor wait lists, gave DSHS access to real-time data relating to the average number of days a client remained on a wait list by region and the statewide average for both adults and youths. The report also reflected the type of interim services a client received upon being placed on a wait list. Additionally, a weekly wait list summary report by provider was also available for review.

The use of the BHIPS Capacity Management System for monitoring capacity was verified through DSHS performance reviews and on-site monitoring visits. The DSHS Quality Management Unit conducted a review of documentation related to the provision of interim

services for pregnant females and IV drug users. They also verified whether providers encouraged substance abusers in need of treatment to receive treatment and assisted them in accessing services in a timely and efficient manner. DSHS's Quality Management Unit also reviewed the provider's current waiting list to determine the program's mechanism used in maintaining contact with the individual awaiting admission to treatment. Quality Management Unit visits resulted in a range of recommendations, which included technical assistance support and/or sanctions.

In the upcoming year when BHIPS is converted to the Clinical Management for Behavioral Health Services (CMBHS) suggestions will made be to expand the Capacity Management function within the new system to allow providers to report actual adult and youth availability in all level of services separately. Additionally, the Outreach, Screening, Assessment and Referral Services (OSAR) agencies will maintain the centralized residential waitlist in each region. Outpatient waitlist will continue to be maintained by the individual provider.

Texas
Goal #10: Process for Referring

GOAL # 10. An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. 300x-28(a) and 45 C.F.R. 96.132(a)).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

GOAL 10 – Process for Referring

FY 2006 (Compliance): Texas residents who met financial guidelines and had been diagnosed as having a substance use disorder (DSM IV-TR) were eligible for DSHS services. DSHS clients remained in treatment as long as there was a documented clinical need for continued services.

OSAR providers served as the front door to local treatment services for specific geographic areas. Every HHSC region had at least one OSAR, and two of the more populated regions were served by two OSARs. In seven counties around the Dallas metroplex, NorthSTAR provided the same functions as the OSAR. OSARs were responsible for providing information and outreach to their identified service areas and maintaining close working relationships with local treatment providers. Individuals and organizations inquiring about services by phone or via the Internet were directed to the appropriate OSAR location for screening, assessment, and referral.

OSARs matched clients to appropriate services using the assessment tool found in BHIPS. They identified appropriate services using the capacity and waiting list data found in BHIPS, and gave clients a choice of appropriate providers and their contact information. When necessary, OSARs also communicated with each other across regions to facilitate referrals and allow priority population patients to access services more quickly. When possible, OSARs scheduled an appointment for the client with the chosen provider to promote successful follow-through. After obtaining client consent, OSARs shared assessment results with the provider through BHIPS.

In FY 2006, more effective use of the continuum of care was achieved by strengthening the process for client referral and capacity management. Routine follow-up determines if clients were matched to and/or received the type and level of services most appropriate to their individual needs. OSARs gave providers regular feedback on client placement and service utilization based on placement criteria and length of stay guidelines developed and implemented in FY 2004.

The state maintained its “no wrong door” policy, allowing treatment providers to perform assessments and, when necessary, provide referrals for individuals applying to them directly for services. The role of OSARs was expanded, however, to include performing gatekeeper functions for residential treatment slots. OSARs were required to authorize each residential admission after verifying that the BHIPS assessment documented a clinical need for that level of service. This OSAR gate keeping function was limited to residential services; other funded services such as outpatient, detox, and opiod replacement therapy did not require OSAR approval for admission.

In FY 2006, the referral process continued to benefit from the comprehensive functionality of BHIPS, which was fully implemented in FY 2004. Data from BHIPS enabled providers to identify need, demand and gaps in service. The capacity management function helped providers locate appropriate services for clients more quickly, and allowed them to access client records electronically concurrent with the physical referral of the client. Through the BHIPS system the state was able to maximize limited resources by providing information to the general public, referral sources, potential clients and treatment providers so that clients could be more effectively and efficiently matched with services that best met their needs.

GOAL 10 – Process for Referring

FY 2008 (Progress): DSHS contracts with Outreach, Screening, Assessment and Referral providers located in all regions of the state to serve all but the seven NorthSTAR counties. OSARS serve as the front door, but DSHS maintains its "no wrong door" policy for clients entering services. Clients access DSHS Substance Use Disorder treatment services via self referral and through referral from a variety of sources including courts, criminal justice and juvenile justice agencies, physicians and hospitals, families, employers, the Department of Family and Protective services and other state agencies, community-based mutual support organizations (AA, NA, etc.), and treatment providers. Eligible clients residing in areas served by NorthSTAR are initially enrolled in services, and then assessed and referred for treatment to NorthSTAR-contracted providers.

Referral data from FY 2007 was reviewed for appropriateness of placement and provider compliance with the new placement criteria. Review of the data shows higher utilization of outpatient services while continuing to maintain residential capacity. DSHS conducted a series of regional face-to-face meetings with OSARS, treatment providers, and referring agencies to present data on placement decisions and outcomes and to solicit input on revisions to the placement and approval process. To better reach youth in need of treatment, each OSAR developed a plan to improve the communication with youth prevention services within their regions of responsibility, especially the Youth Prevention Indicated programs.

DSHS also launched a major motivational enhancement training initiative to improve referral and treatment. All OSAR and treatment staff are required to have training in motivational interviewing, and DSHS has provided training sessions throughout the state. The new initiative is a partnership with the Health Behavior Research and Training Institute of the University of Texas, and includes intensive workshops paired with individualized coaching for participants to help them apply and improve their motivational interviewing skills.

The 80th Texas Legislature funded a new initiative for the 2008-2009 biennium to improve the local delivery of behavioral health crisis services. The legislation channels the new funding through local mental health authorities, but it provides a new opportunity to better coordinate and integrate local response to substance use in addition to mental health crises. Recommendations were developed by a statewide task force of diverse experts and stakeholders, including advocates and consumers, professionals, providers, and representatives from law enforcement, the courts, psychiatric and emergency medicine, and community services.

Since approximately fifty per cent of individuals experiencing a mental health crisis also have substance use issues, access to substance abuse services is an essential part of crisis redesign. The regional OSARs are partners in the local crisis response teams and provide referrals for substance abuse prevention and treatment services, including detoxification. To support implementation of the crisis redesign initiative, DSHS is providing training for crisis hotline staff and crisis mobile outreach teams.

A milestone in the state's effort to better support service delivery through improved information technology was achieved with pilot implementation of a combined Mental Health and Substance Abuse electronic record. The development of the Clinical Management Behavioral Health Services (CMBHS) was initiated in October 2006, with the goal of expanding the functionality

of BHIPS and integrating the substance abuse and mental health information systems. In FY 2008 selected providers participated in a beta test of CMBHS, which is providing input for continued development. CMBHS will enable electronic sharing of information between Substance Use Disorder and Mental Health treatment providers and contribute to more comprehensive care for clients with co-occurring mental health and substance use disorders.

GOAL 10 – Process for Referring

FY 2009 (Intended Use): In FY 2009, DSHS substance abuse treatment and OSAR contractors will continue to use an electronic clinical records system to ensure appropriate client referral and placement. In FY 2009, providers will transition from BHIPS to CMBHS with training to begin in the winter of 2009. Components of the new system include algorithms providing for calculation of clinically-appropriate service packages for individuals accessing mental health services and clinically-appropriate service level placements for individuals accessing substance use/abuse services. This enhanced functionality of CMBHS will enable DSHS to track and monitor treatment levels of care received more effectively, informing continued efforts to improve matching clients with the most appropriate levels of care.

In 2009, the OSARS will continue to develop referral relationships with the local mental health centers as part of the *Crisis Services Redesign* initiative.

Texas
Goal #11: Continuing Education

GOAL # 11. An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

GOAL 11 – Continuing Education

FY 2006 (Compliance): DSHS continued to provide continuing education units to professionals that work in the substance abuse/mental health field on topics relating to the services and activities that they provide to prevention participants and treatment clients. During FY 2006, the Department sponsored the following training events:

The 49th Annual Institute, the 49th Annual Institute was held July, 03, 2006 through August 4, 2006 and 1,385 persons attended the conference. The conference included a 'Prevention Specialist Training' and a 'Coalition Summit'. The different tracks for the conference itself were Substance Abuse Treatment, Prevention, Mental Health, Community Issues and Collaboration, and Crossing Systems.

The Partners in Prevention Conference, November 2005. DSHS co-sponsored with DFPS with 500 participants in attendance.

The Texas Teen Summit and Comprehensive Tobacco Prevention Conference, July 2006. This provided tobacco prevention and control education to 253 youth and 311 adults representing local law enforcement, local school districts and community-based organizations.

In 2006 the ***HIV Outreach Conference*** was held in Austin, Texas and the ***HIV Early Intervention Conference*** was held on South Padre Island, Texas. Through the HIV Training Services Contractor (HYS), these two conferences were coordinated for the purpose oft updating all SAMHSA-funded DSHS HIV staff on HIV clinical information and to ensure consistency of related prevention message(s) delivered to substance abuse populations at highest risk of infection for HIV, hepatitis, and other communicable diseases.

DSHS also sponsored approximately 52 Topic-Specific Trainings in FY 2006.

GOAL 11 – Continuing Education

FY 2008 (Progress): DSHS continues to further develop its training system by offering workshops and conferences that provide courses in research-based methods and strategies for preventing and treating substance use/abuse and mental health problems.

For FY 2008 the HIV Early Intervention Conference was held September 10th through the 12th in Corpus Christi and the HIV Outreach Conference was held July 21st through the 23rd in Austin. As in the past, the purpose of these conferences is to update all SAMHSA-funded DSHS HIV staff on HIV clinical information and to ensure consistency of related prevention message(s) delivered to substance abuse populations at highest risk of infection for HIV, hepatitis, and other communicable diseases.

2008 Annual Institute, August 24th through August 29th. For nearly 50 years, the state of Texas has held a week-long conference in July or August in Austin that included substance abuse prevention and treatment sessions. During the past three years, the conference has changed its name to the Texas Behavioral Health Institute and for the first time moved the Institute to Dallas. The Institute has added mental health, criminal justice, workforce and non-profit leadership tracks. In FY 08 there were 1388 participants. Continuing education credits were offered for Licensed Chemical Dependency Counselors, Licensed Professional Counselors, Therapists, Probation Officers, Social Workers and Health Educators.

In addition to the annual training institute, the training unit within the MHSA Division of DSHS has conducted and/or sponsored approximately 45 trainings statewide that included, the following topics: Cognitive Behavioral Therapy (CBT); Cannabis Youth Treatment (CYT); Wrap Around Engagement; Suicide Prevention (QPR); Motivational Interviewing (MI); Texas recommended Guidelines (TRAG); Co-Occurring Psychiatric Substance Disorders COPSD; Barkley defiant children and Trauma Informed Services; ATR II; Trauma Informed Services with Seeking Safety; Behavioral Health Integrated Provider System (BHIPS); Clinical Management for Behavioral Health Services (CMBHS) . In addition, the training unit within the MHSA Division of DSHS contracted with American Association of Suicidology to provide all training related needs to the Crisis Redesign Initiative to include Crisis Hotline Worker training with certification and Mobile Crisis Outreach Team training. The training unit within MHSA Division of DSHS also partnered with the University of Texas Social Work Department through their Addiction Technology Transfer Center (ATTC) & Addiction Study Center to offer Motivational Interviewing training for staff and providers.

The above-listed trainings were open to both mental health and substance abuse providers statewide. Some of the trainings above are follow-up trainings from initial trainings that were conducted in FY 2007 for fidelity purposes, and some were repeat trainings for providers that were unable to attend the initial trainings in FY 2007.

The Texas Teen Summit and Comprehensive Tobacco Prevention Conference will be held July 27 -30, 2008 and will provide tobacco prevention and control education to approximately 550 youth and adults representing local law enforcement, local school districts and community-based organizations

GOAL 11 – Continuing Education

Training events continue to be conducted in state-owned facilities and contracted hotels in a variety of regions in the state. Training locations were determined by the locations most accessible to the largest concentration of funded providers. Trainings were conducted by contracted vendors/developers from around the country and by DSHS's training/TA staff with subject matter expertise in a variety of relevant areas.

GOAL 11 – Continuing Education

FY 2009 (Intended Use): In FY 2009, DSHS intends to further develop its training system by offering workshops and conferences that will continue to move towards only Evidence-based Practices and strategies for preventing and treating substance use/abuse and mental health problems.

In addition to the annual training institute and the conferences held in FY 08, the training unit within the MHSA Division of DSHS is anticipating conducting and/or sponsoring around 50 trainings statewide that will include, but not be limited to, the following topics: Cannabis Youth Treatment (CYT); Suicide Prevention (QPR); Motivational Interviewing (MI); Texas recommended Guidelines (TRAG); Co-Occurring Psychiatric Substance Disorders COPSD; BHIPS;CHMBS; Crisis Hotline Worker Training; Mobile Crisis Outreach Team Training (MCOT);and Trauma Informed Services. The above-listed trainings will be open to both mental health and substance abuse providers statewide when applicable.

In addition, the training unit plans to be a part of the development and implementation of training associated with several new DSHS initiatives such as the Preparedness Training Project Charter that was initiated in fiscal year 2008. As indicated, all trainings conducted by the training unit are offered to funded mental health and substance abuse providers statewide.

Prevention trainings will continue to be provided by the single statewide Coordinated Training System (CTS) contractor, which is currently contracted to provide evidence-based prevention trainings in six domains for all funded prevention programs around the state as well as HIV and communicable disease trainings.

The contract to conduct The Texas Teen Summit and Comprehensive Tobacco Prevention Conference is being renewed for 2009. The conference will be held July 2009 and will provide tobacco prevention and control education to approximately 550 youth and adults representing local law enforcement, local school districts and community-based organizations.

Training events are normally conducted in state-owned facilities and contracted hotels in a variety of urban regions in the state. Training locations are determined by the locations most accessible to the largest concentration of funded providers. Trainings will be conducted by contracted vendors/developers from around the country and by DSHS's training/TA staff with subject matter expertise in a variety of relevant areas.

Texas
Goal #12: Coordinate Services

GOAL # 12. An agreement to coordinate ,prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. 300x-28(c) and 45 C.F.R. 96.132(c)).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

GOAL 12 – Coordinate Services

FY 2006 (Compliance): In FY 2006, DSHS's direct service prevention programs were delivered primarily in the schools using curricula identified as effective by the CSAP/NREP process. These prevention programs were required to establish linkages and coordinate with other community resources and treatment providers to facilitate referrals for family members identified as having a substance abuse or dependence problem. Other prevention programs had specific responsibilities for broader coordination efforts. The Prevention Resource Centers (PRC) provided information and coordination of regional training services across the state. And the Community Coalitions were designed to bring prevention and treatment providers together with other community stakeholders to address community substance abuse issues.

Outreach, Screening, Assessment and Referral (OSAR) providers were responsible for referrals and service coordination for treatment, prevention and other community services through a variety of strategies. In addition to making referrals to prevention and early intervention programs, they managed admissions and lengths of stay in residential treatment. The OSARs maintained residential treatment waiting lists for all regions and referred clients to appropriate levels of care as soon as a bed slot became open. The OSARs delivered or arranged for interim services for individuals on the wait list, and also linked them with services outside of the treatment or prevention continuum, as needed, during the waiting period or to augment treatment. OSARS were charged with maintaining current information about various resources in their communities and coordinating prevention and treatment activities with other appropriate ancillary and support services.

Treatment programs were required to establish links and formal agreements with available substance abuse and other mental health, health care and social service providers to address the multi-dimensional needs of individual clients, and to facilitate referrals for family members needing services. For example, a treatment provider might refer an adolescent whose parent was in treatment to an appropriate prevention or early intervention program, where the adolescent could receive support and education regarding the parent's substance use/abuse issues. Treatment programs provided case management and referred clients to ancillary services needed to help clients meet treatment goals. They also conducted follow-up with clients leaving treatment or on waiting lists to ensure clients and referral sources successfully made contact and clients were accessing needed services and supports.

Drug Demand Reduction Advisory Committee (DDRAC) which is a state mandated committee consisting of 16 state agency participants and five at-large members from different geographical areas within the state continued in FY 06. DDRAC conducted numerous initiatives to build on the legislatively-mandated statewide strategy to reduce drug demand in Texas. Member agencies reached a consensus on the mission, principles, philosophy, goals, and actions to meet the strategic objectives. This was a demonstration of the effectiveness of a multi-faceted statewide strategy. Significant progress was made in strengthening community coalitions, building public and private partnerships involving community organizations, developing outcome-based services, and coordinating among community organizations.

Specialized treatment and intervention programs for persons at risk for HIV and priority female population received ancillary services addressing their specialized needs in coordination with the substance use services. These typically included transportation, childcare and parenting education for pregnant women; and rapid testing, screening and motivational interviewing strategies for individuals at risk for HIV and/or TB.

GOAL 12 – Coordinate Services

Treatment and prevention services were coordinated with other services through several other federal grants.

- The Access to Recovery (ATR) grant used a voucher program to provide treatment and recovery support services for individuals referred through drug courts, child protective services and local probation departments. Recovery support services included individual recovery coaching, employment training and spiritual support, which may contribute to successful treatment outcomes and sustainable recovery gains.
- The Co-Occurring State Incentive Grant (COSIG) provided incentives for completion of treatment and ensured coordination with other necessary services for individuals with co-occurring disorders, including child care, medical services, medications, consultations, education and job training.
- The Screening, Brief Intervention, and Referral to Treatment Initiative (SBIRT) demonstrated a successful framework for integration and coordination of physical and behavioral healthcare services. Patients presenting for primary, inpatient, or emergency medical care were routinely screened for substance use problems by health care staff. Individuals identified as being at risk or impacted by substance use problems received brief intervention and/or treatment from a trained specialist, with referral to specialized substance abuse in the community as needed. Great effort was made to forge an effective system for transitioning clients from the general healthcare setting to community-based substance abuse services to minimize the client drop-out rate typically encountered at the point of referral. This project was a collaborative effort involving the Harris County Hospital District, Houston Council on Alcohol and Drug Abuse, the Steven Sessions Group, the University of Texas Addiction Research Institute, University of Houston Health Sciences Center and Baylor College of Medicine.
- The Rural Border Initiative (RBI) provided outreach and prevention services in rural Texas-Mexico border communities through trained Promotoras/Community Health Workers (an indigenous outreach worker who is responsible for educating and raising awareness of behavioral health and issues within their communities) and a dedicated DSHS position. The initiative included coordination of all appropriate services, including DSHS prevention and treatment services and appropriate ancillary services available in the community or through other funding sources.

The continued development of BHIPS facilitated the service coordination and exchange of information between treatment and prevention providers. This system also helped to identify the need for and to facilitate referrals to other appropriate services, supporting a more holistic approach to service delivery for individuals with substance use problems.

GOAL 12 – Coordinate Services

FY 2008 (Progress)*:* In FY 2008, DSHS continues to promote coordination of prevention, treatment and other appropriate services through its policies and programs, grants and contracts, MOUs, BHIPS functionality, special initiatives, and ongoing communication and collaboration with service providers and other service systems and agencies.

Direct service prevention programs continue to coordinate with other community resources and treatment providers to facilitate referrals for participants and family members, while PRCs and Community Coalitions work on coordinating community efforts and resources to address substance use issues. DSHS conducted statewide procurement for prevention and intervention services, the first such procurement since FY 2005. The RFP introduced a behavioral health prevention framework to allow a more holistic approach to prevention across the state.

Treatment programs remain responsible for identifying and coordinating resources needed to support each client's treatment and recovery needs through written agreements and other linkages. In preparation for the FY 2009 Treatment RFP, DSHS launched a new project to identify strategies to improve treatment and recovery support. As part of the project, DSHS conducted meetings across the state involving a statewide group of experts and stakeholders to consider evidence and offer recommendations. The top recommendation was to expand availability to recovery support and other community services and to strengthen coordination efforts. Staff is developing plans for implementing those recommendations.

Through OSARs, DSHS continues to enhance coordination of services across the continuum of care. Key strategies in this effort included close collaboration with local prevention and treatment service providers, maintenance of a waiting list, contact with clients, and providing or facilitating interim services. Although each OSAR works primarily within a specific region, OSARS also establish arrangements with providers in other regions to promote timely access to limited services, particularly for priority populations. The BHIPS supports effective coordination across levels of care, service providers and service types by facilitating sharing and exchange of assessments and other client information.

The Rural Border Initiative (RBI) continues to establish specially-trained Community health Workers/Promotores to provide prevention and screening services and engage residents in rural, frontier and border areas of the Texas-Mexico border that are at higher risk for and have less access to substance use/abuse prevention, intervention and treatment services.

In FY 2008, a variety of federal grants continue to provide opportunities for collaboration and coordination between DSHS and other service systems, including the criminal justice and the child protective services systems.

- Through the *COSIG*, treatment is coordinated with other appropriate services in an integrated setting for individuals with co-occurring disorders. Electronic vouchers are used to purchase necessary ancillary services, such as transportation and supportive housing. This grant is enabling many clients to receive services by addressing basic needs that had prevented them from participating in integrated chemical dependency/mental health treatment.

GOAL 12 – Coordinate Services

- DSHS continues to coordinate the SBIRT project with its six partner organizations. FY 2008 is the last year for this grant, which is demonstrating positive outcomes and cost savings through effective integration of physical and behavioral health services.
- The original Access to Recovery grant continued in FY 08. In addition, DSHS received funding for a second *Access to Recovery* grant that funds treatment and recovery support activities, including transitional housing, transportation, medical services, and individual recovery coaching. In FY 08, both grants were providing client services.

The Texas Family Recovery Initiative, a new partnership between DSHS, judicial systems and the mental health and substance abuse service systems is establishing an integrated system of care for pregnant women and women with dependent children who have substance problems. The program is providing and coordinating mental health and substance abuse services with other gender-specific and support services such as counseling for trauma and abuse issues, transportation, childcare and prenatal care.

The 80th Texas Legislature (2007) funded a new initiative for the 2008-2009 biennium to improve the local delivery of behavioral health crisis services. Funding is channeled through local mental health authorities, but it provides an opportunity to better coordinate and integrate local response to substance use and mental health crises. Recommendations were developed by a statewide task force of diverse experts and stakeholders, including advocates and consumers, professionals, providers, and representatives from law enforcement, the courts, psychiatric and emergency medicine, and community services.

Because approximately half of the individuals experiencing a mental health crisis also have substance use issues, access to substance abuse services is an essential part of crisis redesign. The regional OSARs are partners in the local crisis response teams and provide referrals for substance abuse prevention and treatment services, including detoxification. To support implementation of the crisis redesign initiative, DSHS is providing training for crisis hotline staff and crisis mobile outreach teams.

As mentioned in other sections, an effort is underway to develop an electronic health record for both substance abuse and mental health, known as the Clinical Management for Behavioral Health Services (CMBHS) Initiative. This online health record will promote improved coordination of mental health and substance abuse prevention, early intervention and treatment services, as well as coordination with other appropriate services.

GOAL 12 – Coordinate Services

FY 2009 (Intended Use): DSHS will continue to require funded providers to coordinate prevention and treatment with other appropriate services, ensuring a holistic approach and more effective services. Collaboration and coordination will be monitored by contract managers through the electronic record system, desk reviews, and onsite compliance visits.

The Drug Demand Reduction Advisory Committee will continue its efforts to coordinate prevention, treatment, and enforcement strategies to reduce drug demand reduction. In FY 2009, one of its key areas of focus will be data sharing and continuity of services. A subcommittee has been established to develop recommendations for the 81st legislature and participating agencies.

Recovery management will be a key focus of efforts to develop a more comprehensive and flexible treatment system. The goal is to provide increased service options and broader availability of recovery support resources to more effectively address clients' needs at the time they present for services. DSHS will also explore ways to expand the continuum of substance abuse services to include screening and brief intervention, enhance continuity of care and client retention in treatment, and increase coordination among substance use, mental health, and physical health service systems. The FY 2009 RFP will reflect new recommendations and requirements to achieve these objectives. DSHS is also developing a legislative request for additional state revenue to support strategies that require additional resources.

Several federal grant projects will continue providing services in FY 2009.

- The COSIG grant and the COPSD programs will continue to serve clients, and an evaluation will be conducted to determine results of these efforts. The training of mental health providers and substance abuse providers in treating clients with co-occurring disorders will continue, thereby increasing the capacity of the system to coordinate and integrate mental health and substance abuse services effectively for individuals with co-occurring disorders.
- In 2009 DSHS will continue to provide services for treatment and recovery support activities, including transitional housing, transportation, medical services, and individual recovery coaching through the *Access to Recovery* grant
- Although the SBIRT grant is ending in FY 2008, the Harris County Hospital District will be including screening and brief intervention in its regular budget, allowing these services to continue beyond the grant period. Through a no-cost extension, the University of Texas will provide intensive training and coaching to ensure that new staff who are assigned to these functions develop the skills necessary to effectively implement these services.

In FY 2009, one of the main policy initiatives will be the implementation of the Clinical Management for Behavioral Health Services (CMBHS) system. This electronic health record initiative will provide new opportunities for coordination between mental health and substance abuse prevention and treatment services, and between substance abuse treatment, substance abuse prevention and other appropriate services. This will be accomplished through enhancements in functionality that will enable easier exchange of information across service systems and providers. The system is expected to facilitate improved access and outcomes and to ensure uniform service delivery regardless of where clients enter the service system.

GOAL 12 – Coordinate Services

Implementation will require extensive trainings and technical assistance, and DSHS will promote and require participation by all providers.

Changing trends in admission substance abuse diagnoses in treatment, individual client outcomes, and program performance measures will be monitored. Monitoring for prevention services will include participant pre- and post-tests, fidelity to curriculum, and performance measures. Technical assistance will be offered as data is analyzed and trainings on recovery-oriented service provision and evidence-based practices will be provided

Texas

Goal #13: Assessment of Need

GOAL # 13. An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. 300x-29 and 45 C.F.R. 96.133).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

GOAL 13 – Assessment of Need

FY 2006 (Compliance): In FY2006, DSHS utilized several processes to assess the need for both treatment and prevention services in the state. DSHS collected substance-related consequence data such as client treatment, arrest, overdose death, and motor vehicle accidents on a county-by-county basis. These data, along with other information such as the school and household survey data and demographic statistics, assisted with determination of need. Some state and sub-state survey and indicator data was posted on DSHS' website.

Both statewide and regional Texas School Survey of Substance Use (4-6 and 7-12 grades) were completed in 2006, with final reports published and made available online. The school survey provided information to help estimate the need for youth prevention and treatment services at the state and regional level. Prevalence rates determined by the 2003-2006 National Survey on Drug Use and Health for Texas were also applied to estimate the need for adult treatment services at the state and regional level in 2006. The need estimates from the surveys and other indicator data such as population and poverty were factored into the funding formula that guided funding allocation decisions and policy development.

The biannual report of Substance Abuse Trends in Texas which includes drug trafficking, poison cases of drug abuse and other data was used to create the needs assessment. Client and provider data collected through the Behavioral Health Integrated Provider System (BHIPS) data base, which is required for all DSHS providers, was used to assist in assessing the need for treatment services in the state. Client data collected during 2006 was utilized to conduct in-depth analyses of treatment processes and outcomes on a periodic basis. Substance abuse services provided to Hurricanes Katrina and Rita clients were documented in BHIPS. Outcome measures for prevention curricula had been developed and incorporated into BHIPS and reported by prevention providers since September 2004. In addition, a new methodology to assess prevention, which was developed in 2004, enabled identification of prevention needs at the selective and indicated population levels.

The Texas Epidemiological Workgroup (TEW), established in November 2004, served as part of the state prevention framework funded through the State Prevention Framework State Incentive Grant (SPF SIG). The TEW continued to assist the state in its capacity to collect, analyze, and report substance-related consumption and consequence data to support data-driven decision-making in each step of the strategic prevention framework. TEW also provided necessary information and support to the community coalitions on their local needs assessment as well as input on changes in selected prevention indicators.

GOAL 13 – Assessment of Need

FY 2008 (Progress): In FY 2008, substance-related consequence data along with other indicators continue to be updated and inform the needs assessment process. Surveys continue to assist the agency with assessment of need and planning for prevention and treatment. The Texas School Survey of Substance Use conducted in a representative sample of elementary and secondary schools throughout the state has been analyzed and expanded in 2008 to collect regional data as well. Prevalence rates from the National Survey on Drug Use and Health for Texas continue to be applied for the statewide adult needs estimates. Collaboration with the University of Texas Gulf Coast Addiction Technology Transfer Center continues to produce the biannual report of Substance Abuse Trends in Texas through a MOU with DSHS, which includes drug trafficking, poison cases of drug abuse, and other related data.

All DSHS providers continue to use BHIPS, through which an increasing amount of treatment data is collected. Since 2006, substance abuse treatment services provided to Katrina and Rita clients have been documented in BHIPS. More in-depth analyses of treatment services is occurring as the amount of complete data on clients seeking services has become large enough to conduct statistically relevant analyses. A new electronic client health record system, the Clinical Management for Behavioral Health Services (CMBHS), is currently being tested. The CMBHS combines the electronic health recordkeeping requirements for mental health and substance abuse treatment providers in a single system.

The updated methodology from 2004 is currently being used to determine the need for prevention services and guide distribution of funds for universal, selective, and indicated populations in the statewide procurement. Prevention providers continue to report curriculum outcome measures through BHIPS. This information will be used for evaluation purposes. The Adult Survey of Substance Use and Related Risk Behaviors in Seven Major Counties funded by SPF SIG, was conducted in 2008 to help assess community changes and inform prevention efforts. Local needs assessments are also being performed by prevention coalitions through SPF SIG to help identify community problems and develop strategic plans. In addition, a new binge-drinking module is included in the 2008 Texas Behavioral Risk Factors Surveillance System to provide more adult binge drinking data for the regions and assist state and local assessment efforts.

GOAL 13 – Assessment of Need

FY 2009 (Intended Use): In FY 2009, DSHS will continue to collect substance-related data through various data sources and surveys as mentioned in past years. The statewide and regional School Survey of Substance Use, used to assess prevention and youth treatment needs, will be published and reported in 2009. The biannual Substance Abuse Trends in Texas as well as other substance-related information will be updated and posted on the agency website. Data collected through BHIPS on prevention and treatment outcomes will continue to be used to assess how well providers are meeting the needs.

The methodology which was updated in 2004 will continue to be used to assess need for prevention services for universal, selective, and indicated populations. This methodology enables evidence-based prevention programming to better target particular populations in the state. Local needs assessments will continue to be performed by prevention coalitions through SPF SIG. The TEW will continue to provide needed data and support. Also, the Texas Adult Survey of Substance Use and Related Risk Behaviors in Seven Major Counties through SPF SIG will be replicated in 2009 to allow trend analysis and comparison with the baseline survey data, and assess community changes.

Texas

Goal #14: Hypodermic Needle Program

GOAL # 14. An agreement to ensure that no program funded through the block grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. 300x-31(a)(1)(F) and 45 C.F.R. 96.135(a)(6)).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

GOAL 14 – Hypodermic Needle Program

FY 2006 (Compliance): In FY 2006, DSHS adhered to all federal regulations, stating in all contracts the requirement that no funds may be used to provide needles or syringes to anyone. This requirement was monitored through annually-scheduled contract budget reviews. No providers were found to be out of compliance with this regulation.

GOAL 14 – Hypodermic Needle Program

FY 2008 (Progress): In the current FY 2008, all DSHS providers continue to adhere to all federal regulations, including those prohibiting use of federal block grant funds for the purpose of providing individuals with needles or syringes to prevent communicable diseases. FY 2008 contracts include this restriction. Compliance with this regulation/requirement is monitored through contract budget reviews, which are conducted annually during each contract period. As of this date, no providers have been found to be out of compliance with this regulation since it was first monitored in 1994.

In January 2008, training was provided by CSAT to the central office staff and additionally in five strategic locations throughout the state for providers on the requirements of the block grant. The prohibition of providing individuals with needles or syringes to prevent communicable diseases was reviewed.

GOAL 14 – Hypodermic Needle Program

FY 2009 (Intended Use): In FY 2009, federal laws and regulations prohibiting use of SAPT block grant funds to support needle exchange programs will continue and all funded programs will be expected to comply. DSHS will continue to conduct annual contract budget reviews in which the applicable regulations are monitored.

Texas

Goal #15: Independent Peer Review

GOAL # 15. An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

GOAL 15 – Independent Peer Review

FY 2006 (Compliance): In FY 2006, DSHS conducted an Independent Peer Review Process called the Peer Review Quality Improvement Process (PRQIP). The purpose of the PRQIP is to perform quality review through peer review of client records. The annual report prepared by the Peer Review Team and submitted to DSHS contained recommendations for system improvements.

A review team composed of five reviewers was selected by the DSHS's clinical director, with input from the Association of Substance Abuse Providers (ASAP), past reviewers and volunteers. The review team consisted of new members as well as some prior members. The reviewers met in Austin for three days on October 8th, 9th and 10th. in 2006 to perform a review of FY 2005 activities. The review team performed the following activities:

- Planned the focus of the reviews
- Designed the instruments for the assessment
- Ensured that the selection of providers to be reviewed was a representative and random sample
- Planned the BHIPS reviews
- Trained committee members
- Reviewed the selected records in BHIPS
- Summarized the overall findings
- Developed and submitted a report to the clinical director of the DSHS's Program Implementation Section to inform system changes, if indicated.

The MHSA clinical director, representing the single state authority for substance abuse, provided guidance to the review team. The independent peer review process was conducted using the web-based internet capability of BHIPS. The review team convened in November to review treatment records of 15 clients from 6% of treatment providers FY 2005 activities. The clinical director and a staff member from the Program Implementation Unit provided technical assistance to the PRQIP review team.

The PRQIP reviewers compiled and analyzed the data and developed and submitted a report to the clinical director that included system issues and recommendations.

GOAL 15 – Independent Peer Review

FY 2008 (Progress): Each year reviews are conducted in October for the previous FY; records are not closed out until September for the previous year. In FY 2008, the independent peer review process (PRQIP) was conducted to assess and improve the quality and appropriateness of treatment services. The review process was conducted in October of FY 2008 for activities performed by funded providers in FY 2007. The reviewers selected the criteria, developed the instrument, and reviewed the data in BHIPS. The data from the independent peer review process will be collected and analyzed. Since all funded providers are required to utilize BHIPS, the peer reviewers use this system to review client records and conduct the peer review process. Programs/providers reviewed in FY 2008 for FY 2007 activities were randomly selected and notified by mail. The sample collected represents 6% of the treatment providers.

By contract, funded providers are required to participate, by contract, in the PRQIP, if selected. Five peer reviewers were selected by the previous peer review committee. To ensure continuity of last year's processes, the committee composition was maintained from the prior year. The independent peer review process continues to be conducted through the web-based internet capability of BHIPS. The substance abuse clinical director with assistance from a staff member of the Program Implementation Unit facilitated the process during the October review last year in Austin. The random sampling process and selection of providers was completed by the DSHS Decision Support Unit in the Mental Health and Substance Abuse Division.

The reviewers met and analyzed the data and completed a report that was provided to the clinical director for review. The report was utilized to aid the Training and Technical Assistance Unit in formulating their processes, and will continue to be used to inform process improvements for ultimate system improvements. At the date of this writing, random sampling is underway to select records for review. Reviewer selection processes will be initiated in the next few weeks for the independent review process for FY 2008 activities.

GOAL 15 – Independent Peer Review

FY 2009 (Intended Use): In FY 2009, an annual independent peer review process will continue to be conducted as described in the compliance report, and in accordance with the federal requirement to use an Independent Peer Review process to assess and improve the quality and appropriateness of treatment services delivered by funded providers. The Independent Peer Review Process for FY 2008 will be initiated in the fall of 2009. Likewise, the independent peer review process for FY 2009 will occur in the fall of 2010. Five reviewers will be selected with input from the 2008 reviewers and the Association of Substance Abuse Providers (ASAP). With input from the clinical director, reviewers will develop the process, questions and criteria for review. In October of 2008, the reviewers will meet review the previous year's activities of 15 randomly-selected clients from 6% of randomly-selected treatment providers. This volume of providers exceeds the requirement to review 5% of the treatment providers.

Peer reviewers will continue to use the electronic data record keeping system to review automated client records to determine the consistency, continuity and the quality of care that the clients receive. The Division's clinical director and a designated member of the Program Implementation Unit will continue to oversee the PRQIP and assist the peer reviewers in this effort. The peer reviewers will continue to assess the process itself and recommend modifications to the clinical director, if necessary.

The independent peer review process will continue to be conducted through the web-based internet capability of BHIPS. Peer reviewers will be given instructions, and oversight and technical assistance (TA) will be provided during the review process at the BHIPS training facility in Austin. At the end of the review process, the reviewers will summarize their findings and write a report. The report will be shared with the clinical director and the clinical policy group for review. Any appropriate recommendations for system improvements will be provided to the DSHS-MHSA Training and Technical Assistance Unit for training and TA purposes.

Texas
Attachment H: Independent Peer Review

Attachment H: Independent Peer Review (See 45 C.F.R. 96.122(f)(3)(v))
In **up to three pages** provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2007 (See 42 U.S.C. 300x-53(a)(1) and 45 C.F.R. 96.136).

Examples of **procedures** may include, but not be limited to:

• the role of the Single State Agency(SSA) for substance abuse prevention activities and treatment services in the development of operational procedures implementing independent peer review ;

• the role of the State Medical Director for Substance Abuse Services in the development of such procedures ;

• the role of the independent peer reviewers; and

• the role of the entity(ies) reviewed.

Examples of **activities** may include, but not be limited to:

• the number of entities reviewed during the applicable fiscal year ;

• technical assistance made available to the entity(ies) reviewed; and

• technical assistance made available to the reviewers, if applicable.

ATTACHMENT H: Independent Peer Review

As the Single State Authority for substance abuse prevention and treatment services, the DSHS MHSA Division continued to monitor, refine and implement the policies and procedures under which the PRQIP is performed.

I. PROCEDURES INCLUDING ROLES AND RESPONSIBILITIES

The DSHS- Mental Health and Substance Abuse Division serves as the Single State Authority for substance abuse prevention and treatment services.

A. Clinical Director - oversaw the design, implementation, evaluation and monitoring of the PRQIP process. The clinical director performed the following functions:

- Facilitated and approved the on-going refinement of policies and procedures for independent peer review process;
- Acted as the project consultant on clinical matters related to peer record reviews;
- Attended PRQIP reviewer meetings and provided training/TA on treatment issues relevant to peer record reviews.

B. Program Implementation Unit Staff - developed parameters and procedures for the peer review process including assisting with sampling plan for selection of programs being reviewed, development of review instrument, and provision of technical assistance to peer reviewers. Program Implementation staff performed the following functions:

- Coordinated recruitment, selection and training of peer reviewers;
- Assisted with development of sampling plan, review instrument and training materials;
- Mobilized and coordinated the flow of resources between steering committee and the field;
- Provided ongoing technical assistance to peer reviewers and programs being reviewed;
- Responded to conflict of interest or confidentiality issues and maintained documentation.

C. Decision Support/Research and Evaluation Unit – developed and implemented a sampling plan for selection of providers for review, and notified providers that they had been selected to be reviewed under the PQIP.

The Research and Evaluation staff developed a plan for selecting treatment programs for review (the sampling plan) based on a random selection of between four percent and six percent of treatment programs, and maintained documentation of methodology for selecting the programs. The data from the review also aided in the overall training processes.

D. PRQIP Peer Reviewers – reviewed selected providers and records, developed a report and made system recommendations to the clinical director. Peer reviewers

also decided on the parameters and items reviewed in the records to determine quality.

The selected PRQIP peer reviewers had expertise in the field of alcohol and drug abuse treatment. Members of the committee were knowledgeable about the modality being reviewed and the underlying theoretical approach to addictions treatment. They were also sensitive to the cultural and environmental issues that may have influenced the quality of the services provided. Technical assistance was provided to the reviewers by the Program Implementation Unit and the clinical director.

E. Provider Entities Reviewed – treatment programs selected were informed by mail that they would be part of the peer review process. No additional provider preparation was required since reviews were conducted through BHIPS.

II. ACTIVITIES

A. Planning

During the planning stage, the clinical director, DSHS staff and peer reviewers developed the review plan. The PRQIP study focused on the consistency processes for screening, conducting assessments and developing treatment plans. The peer reviewers utilized BHIPS to review client records, representing a change from the previous procedure of on-site visits to providers. BHIPS is a web-based clinical, administrative, and fiscal data collection and billing system. All funded providers were required to utilize BHIPS. Programs to be reviewed were selected by the Research and Evaluation staff using a random sampling methodology and were notified by mail.

DSHS also developed new policy and procedures for PRQIP that indicated that the reviews would be looking at screening, assessment and treatment plans of the randomly-selected programs.

B. Program Reviews

Seven (six percent of total) treatment programs were selected for review. Ten client records were selected at random from each of the treatment programs. Treatment record reviews were performed to determine the consistency of the process of conducting screenings, performing assessments and developing treatment plans. A set of 10 questions that cross-checked data elements in the screening, assessment and treatment plans was utilized by each reviewer. In addition, a check of the records to determine whether the clinical record as a whole justified the type intensity of services delivered.

C. Consensus Meeting

DSHS staff and the reviewers met and analyzed the information collected. Trends

and issues related to quality, effectiveness and appropriateness of treatment services being purchased through the block grant were identified. The peer reviewers evaluated the records (screening, assessment, and treatment plans) as the means to assess the quality of the services, based on their experience as treatment providers.

DSHS and the peer reviewers utilized the information from the PRQIP to aid in the technical assistance training offered to providers and the introduction of a review process for admissions to residential treatment.

The information from the peer review was utilized as a guideline to update the DSHS OSAR Quality Management matrix and it was recommended that OSAR providers utilize this matrix in the development of their own Quality Review Process.

Texas

Goal #16: Disclosure of Patient Records

GOAL # 16. An agreement to ensure that the State has in effect a system to protect patient records from inappropriate disclosure (See 42 U.S.C. 300x-53(b), 45 C.F.R. 96.132(e), and 42 C.F.R. part 2).
FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

GOAL 16 – Disclosure of Patient Records

FY 2006 (Compliance): In FY 2006, all funded prevention, intervention and treatment providers were required by rule to protect client/participant records and client/participant-identifying information from unauthorized disclosure in accordance with 42 C.F.R., Part 2. DSHS Standard of Care Rule 448.508 (b) Client Records states that the facility shall protect all client records and other client-identifying information from destruction, loss, tampering, and unauthorized access, use or disclosure. The provider is required to develop a policy and procedure to address how they will protect client records. This policy requires that the client records are to be kept in a locked location.

Provider compliance with these regulations was monitored through administrative and licensure reviews, audits and other on-site inspections. Providers found to be out of compliance with any aspect of the regulations were required to implement a corrective action plan. DSHS staff modified their compliance review instruments to appropriately address issues regarding prohibitions on disclosure of client/participant records and identifying information. A contract oversight team approach was used to provide input for identifying a provider's area of need. In addition, DSHS provided technical assistance to providers out of compliance with regulations 42 C.F.R., Part 2.

DSHS implemented the laws related to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. BHIPS enables the generation of HIPAA-compliant claims as a by-product of the clinical data when providers entered clinical data into the BHIPS system. HIPAA also required patient information security and DSHS accomplished full compliance with these security standards.

To ensure compliance with this regulation, the DSHS MHSA Quality Management Unit used a variety of mechanisms and data, including Behavioral Health Integrated Provider System (BHIPS), financial and contract data to conduct on-site compliance reviews. In 2006, Quality Management utilized a risk-based approach to determine which providers were higher risk and required monitoring. This tool was based on when the provider was last monitored, provider's total funding, or if the provider was newly funded. The review includes an assessment of provider policies and procedures regarding prohibition on disclosure of client/participant records and identifying information.

GOAL 16 – Disclosure of Patient Records

FY 2008 (Progress): In accordance with 42 C.F.R., Part 2, all DSHS substance abuse prevention and treatment providers continue to be required by rules to protect client/participant records and client/participant-identifying information from unauthorized disclosure. Every treatment facility is required to implement written procedures for protecting and releasing client information and the procedures must conform to the requirements of 42 C.F.R., Part 2. DSHS conducts ongoing monitoring to ensure that HIPAA standards are met and to ensure protection of patient record confidentiality.

To ensure compliance with these regulations, the DSHS MHSA Quality Management Unit has continued to integrate a variety of mechanisms and data, including financial, contract and clinical data from the Behavioral Health Integrated Provider System (BHIPS) to conduct on-site compliance reviews. The Quality Management staff that conduct reviews have undergone intensive instruction in automated auditing software and programmatic cross-training to ensure adherence to review protocols. On-site reviews, internal monitoring and performance reviews of selected prevention, intervention and treatment providers are conducted using a performance-based risk assessment. The risk assessment tool is based on 16 indicators and 4 clusters. The clustering process was based on the clinical perspective and practical aspect of each indicator and cluster rather than pure statistical procedures. The indicators are based on percentile ranking as compared to other providers. Additionally, Quality Management conducts more in-depth, internal, focused reviews via BHIPS if enhanced monitoring of providers is indicated.

The on-site reviews include a review of provider policies and procedures regarding prohibitions on disclosure of client/participant records and identifying information. Reviews of procedures used to comply with records retention requirements are performed. The Quality Management Unit provides contractors with programmatic monitoring tools located on the agency's web-site. These tools can be used to assist them in developing a quality management process that will identify program deficiency detection by their funding entity.

GOAL 16 – Disclosure of Patient Records

FY 2009 (Intended Use): In FY 2009, in accordance with 42 C.F.R., Part 2, all DSHS substance abuse prevention and treatment providers will continue to be required by rules to protect client/participant records and client/participant-identifying information from unauthorized disclosure. Every treatment facility will continue to be required to implement written procedures for protecting and releasing client information, consistent with the requirements of 42 C.F.R., Part 2. DSHS continues ongoing monitoring to ensure HIPAA standards are met, ensuring protection of patient record confidentiality.

To ensure compliance with these regulations, the DSHS MHSA Quality Management Unit will continue its work on integrating a variety of components, including BHIPS, financial and contract data, and the risk assessment tool. These components will be used to conduct on-site compliance reviews, internal monitoring and performance reviews of selected prevention, intervention and treatment providers. The risk assessment tool was piloted in FY 2007 to test validity of the tool. This instrument was fully implemented in FY 2008, with quarterly use of the risk assessment tool on an ongoing basis. Additionally, Quality Management staff will utilize more in depth, internal focused reviews via BHIPS to enhance monitoring of providers. The reviews will include a review of provider policies and procedures regarding prohibitions on disclosure of client/participant records and identifying information and compliance with records retention requirements. DSHS will continue to provide training on client confidentiality and technical assistance, as needed

Texas
Goal #17: Charitable Choice

GOAL # 17. An agreement to ensure that the State has in effect a system to comply with services provided by non-governmental organizations (See 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(b) and 54.8(c)(4), Charitable Choice Provisions; Final Rule (68 FR 189, pp. 56430-56449, September 30, 2003).

FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

GOAL 17 – Charitable Choice

FY 2006 (Compliance): In FY 2006, the state had a system in effect to comply with Charitable Choice regulations. To strengthen the requirement for funded service providers, the following provision was added to the general provisions of the DSHS FY 05 Substance Abuse Services Performance Contracts:

Section 15.01. Charitable Choice. As applicable, Contractor will comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (42 C.F.R. 54.8(c)(4) and 54.8(b), Charitable Choice Provisions and Regulations. The Contractor will use the model notice provided in the regulations.

This contract provision required faith-based providers to inform clients of their choice options for treatment and offer alternatives prior to admission. These requirements are described further as follows:

Inform Recipients. A faith-based provider must ensure that recipients are advised of the following:

- Provider's religious character
- Recipients' freedom not to engage in religious activities, and
- Recipients' right to receive services from an alternate provider.

Alternatives. If the client objects to the religious nature of the program, the provider must be prepared to offer an accessible, high-quality alternative service with another provider in the same location. The faith-based provider must have made advance arrangements with the alternate provider, which includes access and transportation to the nearby provider.

Charitable Choice provisions were monitored by review of the progress notes and clinician notes for a sample of clients. Reviews were conducted to monitor all services provided to clients and to monitor decisions made by the provider regarding the client.

GOAL 17 – Charitable Choice

FY 2008 (Progress): In FY 2008, the state continues to have a system in effect to comply with Charitable Choice regulations. To strengthen the requirement for funded service providers, the following provision was added to the general provisions of the DSHS FY 2005 Substance Abuse Services Performance Contracts:

The following provision, applicable to all block grant funded contractors, continues to be included in the general provisions of the DSHS FY 2009 Substance Abuse Services Performance Contracts.

Section 15.01. Charitable Choice. As applicable, Contractor will comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (42 C.F.R. 54.8(c)(4) and 54.86(b), Charitable Choice Provisions and Regulations. The Contractor will use the model notice provided in the regulations.

This contract provision requires providers to inform clients and offer alternatives prior to admission.

Inform Recipients. A faith-based provider must ensure that recipients are advised of the following:

- Provider's religious character
- Recipients' freedom not to engage in religious activities, and
- Recipients' right to receive services from an alternate provider.

Alternatives. If the client objects to the religious nature of the program, the provider must be prepared to offer an accessible, high-quality alternative service with another provider in the same location. The faith-based provider must have made advance arrangements with the alternate provider, which includes planning access and transportation to the nearby provider. With the introduction of Outreach, Screening, Assessment and Referral Providers (OSAR) in 2005, the faith-based provider may refer the client to the OSAR to provide an alternate program option.

GOAL 17 – Charitable Choice

FY 2009 (Intended Use): In FY 2009, the state will continue to have a system in effect to comply with Charitable Choice regulations. The following provision, applicable to all funded contractors, will continue to be included in the general provisions of the DSHS FY 2009 Substance Abuse Services Performance Contracts.

Section 19.01 Charitable Choice. As applicable, Contractor will comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (42 C.F.R. 54.8(c)(4) and 54.86(b), Charitable Choice Provisions and Regulations. The Contractor will use the model notice provided in the regulations.

This contract provision will continue to require providers to inform clients and offer alternatives prior to admission.

Inform Recipients. A faith-based provider will be required to ensure that recipients are advised of the following:

- Provider's religious character
- Recipients' freedom not to engage in religious activities, and
- Recipients' right to receive services from an alternate provider.

Alternatives. If the client objects to the religious nature of the program, the provider will be required to be prepared to offer an accessible, high-quality alternative service with another provider in the same location. The faith-based provider will have to have made advance arrangements with the alternate provider, which includes planning access and transportation to the nearby provider. The faith-based provider will continue to refer the client to the Outreach, Screening, Assessment and Referral Program to provide an alternate program option.

For FY 2009, the MHSA Quality Management Unit will continue to conduct reviews on any complaint received regarding clients not being provided an alternative provider. To date in FY 2008 there have been no complaints pertaining to this issue.

State: Texas

Attachment I: Charitable Choice

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

For the fiscal year prior (FY 2008) to the fiscal year for which the State is applying for funds check the appropriate box(es) that describe the State's procedures and activities undertaken to comply with the provisions.

Notice to Program Beneficiaries -Check all that Apply

- [x] Used model notice provided in final regulations
- [ ] Used notice developed by State (Please attach a copy in Appendix A)
- [ ] State has disseminated notice to religious organizations that are providers
- [x] State requires these religious organizations to give notice to all potential beneficiaries

Referrals to Alternative Services -Check all that Apply

- [ ] State has developed specific referral system for this requirement
- [x] State has incorporated this requirement into existing referral system(s)
- [ ] SAMHSA's Treatment Facility Locator is used to help identify providers
- [ ] Other networks and information systems are used to help identify providers
- [ ] State maintains record of referrals made by religious organizations that are providers
- [ ] Enter total number of referrals necessitated by religious objection to other substance abuse providers ("alternative providers"), as defined above, made in previous fiscal year. Provide total only; no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

Charitable Choice provisions are incorporated in DSHS rules, as described in Goal 17. For FY 2007, training courses were designed and customized based on the needs indicated through performance deficiencies or a provider consensus of needed training on a specific topic. During fiscal Year 2007, the substance abuse provider group did not request training regarding charitable Choice. If providers develop a large interest in training on charitable choice, technical assistance can be given to that individual provider. The DSHS website includes links to these rules to advise providers and the general public of the requirements. As needed, DSHS offers courses on the rules provisions to participants from local governments and faith-based community organizations. The needs of providers subject to charitable choice provisions will guide the development of future training modules or formats that may be developed in response to expressed needs. During FY 2008 CSAT provided trainers who delivered four sessions on all of the block grant requirements which included charitable choice information. The trainings were held in Austin, Dallas, Houston and Lubbock in January 2008. The Austin training was held for state central office staff and the other three trainings were held for contracted providers.

- Foot Notes

Re total number of referrals necessitated by religious objection to other substance abuse providers -- DSHS does not track this information.

State: Texas

Attachment J

If your State plans to apply for any of the following waivers, check the appropriate box and submit the request for a waiver at the earliest possible date.

☐ To expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children (See 42 U.S.C. 300x-22(b)(2) and 45 C.F.R. 96.124(d)).

☐ Rural area early intervention services HIV requirements (See 42 U.S.C. 300x-24(b)(5)(B) and 45 C.F.R. 96.128 (d))

☐ Improvement of process for appropriate referrals for treatment, continuing education, or coordination of various activities and services (See 42 U.S.C. 300x-28(d) and 45 C.F.R. 96.132(d))

☐ Statewide maintenance of effort (MOE) expenditure levels (See 42 U.S.C. 300x-30(c) and 45 C.F.R. 96.134(b))

☐ Construction/rehabilitation (See 42 U.S.C. 300x-31(c) and 45 C.F.R. 96.135(d))

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

- Foot Notes

N/A

Texas
Attachment J: Waivers

Attachment J: Waivers
If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

N/A

Form 4

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

State: Texas

Dates of State Expenditure Period: From: 9/1/2005 To: 8/31/2006

	Source of Funds					
Activity	**A.SAPT Block Grant FY 2006 Award (Spent)**	**B.Medicaid (Federal, State and Local)**	**C.Other Federal Funds (e.g., Medicare, other public welfare)**	**D.State Funds**	**E.Local Funds (excluding local Medicaid)**	**F.Other**
Substance Abuse Prevention* and Treatment	$ 92,061,919	$ 0	$ 7,393,824	$ 16,944,212	$ 0	$ 148,036
Primary Prevention	$ 34,388,196		$ 3,564,716	$ 5,567,196	$ 0	$ 0
Tuberculosis Services	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
HIV Early Intervention Services	$ 6,774,380	$ 0	$ 0	$ 403,503	$ 0	$ 0
Administration: Excluding Program/Provider	$ 2,263,111		$ 0	$ 1,435,602	$ 0	$ 10,095
Column Total	**$135,487,606**	**$0**	**$10,958,540**	**$24,350,513**	**$0**	**$158,131**

***Prevention other than Primary Prevention**

Form 4ab

State: Texas

Form 4a. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2006	Other Federal	State Funds	Local Funds	Other
Information Dissemination	$ 0	$ 0	$ 0	$ 0	$ 0
Education	$ 0	$ 0	$ 0	$ 0	$ 0
Alternatives	$ 0	$ 0	$ 0	$ 0	$ 0
Problem Identification & Referral	$ 0	$ 0	$ 0	$ 0	$ 0
Community Based Process	$ 0	$ 0	$ 0	$ 0	$ 0
Environmental	$ 0	$ 0	$ 0	$ 0	$ 0
Other	$ 0	$ 0	$ 0	$ 0	$ 0
Section 1926 - Tobacco	$ 129,214	$ 0	$ 0	$ 0	$ 0
Column Total	**$129,214**	**$0**	**$0**	**$0**	**$0**

Form 4b. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2006	Other Federal	State Funds	Local Funds	Other
Universal Indirect	$ 4,755,889	$ 2,621,023	$ 884,411	$ 0	$ 0
Universal Direct	$ 11,527,680	$ 0	$ 2,275,941	$ 0	$ 0
Selective	$ 8,060,518	$ 242,344	$ 1,129,096	$ 0	$ 0
Indicated	$ 9,914,895	$ 701,349	$ 1,277,748	$ 0	$ 0
Column Total	**$34,258,982**	**$3,564,716**	**$5,567,196**	**$0**	**$0**

Form 4c

Resource Development Expenditure Checklist

State: Texas

Did your State fund resource development activities from the FY 2006 SAPT Block Grant?

(•) **Yes** ( ) **No**

Expenditures on Resource Development Activities are:

( ) **Actual** ( ) **Estimated**

Activity	Column 1 Treatment	Column 2 Prevention	Column 3 Additional Combined	Total
Planning, Coordination and Needs Assessment	$ 248	$ 86	$ 0	$ 334
Quality Assurance	$ 2,851,630	$ 992,170	$ 0	$ 3,843,800
Training (post-employment)	$ 154,306	$ 53,688	$ 0	$ 207,994
Education (pre-employment)	$ 0	$ 0	$ 0	$ 0
Program Development	$ 1,067,716	$ 371,491	$ 0	$ 1,439,207
Research and Evaluation	$ 0	$ 0	$ 0	$ 0
Information Systems	$ 597,593	$ 207,921	$ 0	$ 805,514
Column Total	**$4,671,493**	**$1,625,356**	**$0**	**$6,296,849**

Form 6

SUBSTANCE ABUSE ENTITY INVENTORY

State: Texas

				FISCAL YEAR 2006			
1. Entity Number	**2. I-SATS ID** [X] if no I·SATS ID	**3. Area Served**	**4. State Funds** (Spent during State expenditure period)	**5. SAPT Block Grant Funds for Substance Abuse Prevention and Treatment Services (other than primary prevention)**	**5a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children**	**6. SAPT Block Grant Funds for Primary Prevention**	**7. SAPT Block Grant Funds for Early Intervention Services for HIV** (if applicable)
10	TX902647	Metroplex	$107,946	$777,896	$441,540	$0	$0
10272	TX000510	Northwest Texas	$21,388	$195,262	$0	$0	$0
1030	x	Lower South Texas	$67,758	$0	$0	$451,854	$0
10431	x	Upper Rio Grande	$80,716	$0	$0	$78,997	$0
10432	x	Upper Rio Grande	$90,165	$231,160	$0	$93,551	$0
10485	x	Lower South Texas	$0	$93,270	$0	$0	$0
10497	x	Central	$25,736	$0	$0	$145,672	$0
106	x	Gulf Coast	$440,820	$357,018	$0	$1,815,246	$0
1077	x	Lower South Texas	$28,596	$0	$0	$158,044	$0
1122	x	Central	$259,334	$49,192	$0	$185,122	$0
11451	TX000501	Gulf Coast	$74,456	$554,903	$0	$0	$0
11500	x	Metroplex	$0	$0	$0	$0	$51,698
117	x	Upper South Texas	$118,835	$0	$0	$908,749	$0
12135	x	Statewide (optional)	$29,112	$376,359	$376,359	$0	$0
131	x	Metroplex	$51,009	$0	$0	$299,357	$0
1316	x	Upper South Texas	$17,964	$0	$0	$343,712	$0
133	TX902431	Central	$101,796	$193,539	$25,781	$127,461	$0
1341	TX103378	Metroplex	$170,005	$1,418,053	$0	$0	$0
1567	x	Metroplex	$46,049	$0	$0	$299,439	$0
1576	TX101257	Gulf Coast	$77,637	$572,094	$0	$0	$0
1579	TX104285	Metroplex	$15,804	$106,713	$0	$0	$0
1636	TX112692	Northwest Texas	$291,536	$377,764	$0	$681,959	$0
17	TX102867	Central	$158,824	$1,601,951	$643,613	$0	$0
18	TX100028	Central	$249,908	$1,094,395	$0	$0	$595,753
1810	x	Upper South Texas	$65,999	$0	$0	$490,255	$0
1842	x	Metroplex	$33,018	$0	$0	$235,079	$0
199	TX750103	High Plains	$12,198	$101,034	$0	$0	$0
2	x	Statewide (optional)	$205,935	$0	$0	$1,249,201	$531,408
213	TX904999	Gulf Coast	$58,685	$423,165	$0	$0	$0
215	TX751242	Upper South Texas	$53,742	$598,175	$0	$0	$0
216	TX751259	Upper South Texas	$38,076	$1,023,344	$743,164	$0	$0
217	TX750350	Lower South Texas	$320,240	$1,588,504	$258,055	$0	$0

221	TX905103	High Plains	$23,939	$165,192	$72,930	$0	$0
222	TX000500	Metroplex	$482,044	$2,085,855	$1,210,027	$519,582	$0
228	x	Northwest Texas	$249,581	$252,553	$0	$403,056	$0
231	TX752265	Lower South Texas	$198,885	$782,125	$182,759	$995,738	$0
242	TX904775	Gulf Coast	$104,986	$217,895	$0	$655,880	$0
25	TX905012	Gulf Coast	$109,382	$36,948	$0	$0	$1,071,385
2508	x	Statewide (optional)	$4,345	$0	$0	$129,214	$0
255	x	Upper East Texas	$14,786	$0	$0	$149,088	$0
256	TX000506	Central	$44,935	$44,743	$0	$629,001	$0
26	TX908602	High Plains	$57,637	$494,761	$0	$117,163	$0
260	TX103105	Central	$124,070	$655,528	$223,217	$345,082	$0
261	TX109169	Lower South Texas	$120,751	$671,669	$261,318	$643,847	$58,673
2624	x	West Texas	$110,461	$195,110	$0	$152,527	$0
2645	TX101661	Statewide (optional)	$695,518	$0	$0	$0	$0
2686	x	Gulf Coast	$188,491	$0	$0	$915,649	$79,519
2698	x	Metroplex	$26,706	$345,639	$345,639	$0	$0
2726	x	Upper East Texas	$23,270	$0	$0	$273,351	$0
2866	x	Metroplex	$38,132	$0	$0	$219,362	$0
293	x	Statewide (optional)	$0	$80,031	$0	$0	$0
2974	x	Metroplex	$121,503	$0	$0	$769,118	$0
2978	TX118228	Upper South Texas	$16,347	$57,485	$0	$58,013	$0
2981	TX109862	Upper South Texas	$39,834	$91,171	$0	$155,615	$0
2987	TX000507	Upper South Texas	$11,608	$93,268	$0	$0	$0
3040	x	Metroplex	$73,496	$0	$0	$537,693	$0
3178	TX109177	Lower South Texas	$91,998	$771,130	$132,353	$477,639	$0
3184	x	Upper South Texas	$10,125	$0	$0	$59,838	$0
3207	TX112007	Lower South Texas	$431,962	$658,686	$0	$245,012	$0
3268	TX000503	Metroplex	$42,369	$468,353	$0	$0	$0
3285	TX106736	Gulf Coast	$295,027	$3,220,733	$1,998,855	$0	$0
33	TX300107	Upper South Texas	$186,808	$996,389	$0	$0	$0
3315	TX101846	Gulf Coast	$78,478	$598,169	$0	$0	$0
3352	TX118137	Gulf Coast	$54,811	$928,758	$0	$0	$0
3387	x	Metroplex	$6,060	$0	$0	$76,046	$416,487
3397	x	Lower South Texas	$25,296	$0	$0	$0	$255,277
340	TX300016	Upper Rio Grande	$457,874	$2,860,064	$1,131,531	$882,897	$157,713
342	TX303093	Gulf Coast	$231,733	$2,013,192	$137,517	$331,880	$415,013
344	x	Gulf Coast	$152,934	$0	$0	$913,990	$0
3447	x	Statewide (optional)	$0	$80	$0	($9,115)	$0
345	TX100622	Lower South Texas	$96,613	$774,516	$0	$0	$0
3455	x	Lower South Texas	$25,248	$0	$0	$142,877	$0
349	TX102891	High Plains	$3,411	$56,594	$0	$0	$0
3496	TX110241	High Plains	$264,424	$1,987,242	$565,217	$1,132,431	$76,433
3512	x	High Plains	$5,299	$0	$0	$20,722	$0
354	TX303366	Upper South Texas	$365,544	$2,143,045	$858,169	$0	$173,540
3544	x	Upper South Texas	$0	$185,957	$0	$0	$0
3577	TX110043	Central	$80,137	$290,926	$0	$0	$0
358	TX303051	Gulf Coast	$99,797	$449,387	$0	$0	$0
359	x	Metroplex	$17,431	$0	$0	$325,875	$0
3605	x	Upper East Texas	$30,565	$303,725	$0	$0	$149,986
3660	x	Metroplex	$22,972	$0	$0	$70,051	$0

3663	x	Metroplex	$78,254	$0	$0	$357,905	$0
3679	x	Lower South Texas	$63,437	$0	$0	$297,904	$223,493
3692	x	Upper South Texas	$2,910	$0	$0	$0	$255,406
3695	x	Metroplex	$0	$0	$0	$0	$0
3700	TX121362	Metroplex	$471,441	$1,939,661	$0	$1,335,833	$0
3705	TX112205	Upper East Texas	$42,946	$262,433	$0	$0	$0
3759	TX116230	Upper East Texas	$41,343	$477,141	$0	$0	$0
3778	x	Central	$242,209	$322,843	$0	$0	$0
3793	TX113658	Gulf Coast	$30,250	$254,552	$9,421	$0	$0
3795	TX116289	Gulf Coast	$141,777	$1,236,034	$0	$0	$0
3810	x	Metroplex	$107,271	$0	$0	$1,063,841	$0
3823	TX106702	Gulf Coast	$176,470	$1,266,371	$0	$0	$0
3890	x	Metroplex	$26,449	$0	$0	$145,040	$0
39	TX302954	High Plains	$223,114	$392,781	$0	$0	$71,011
3909	TX120950	Northwest Texas	$47,544	$190,747	$0	$0	$0
3910	TX120240	Upper East Texas	$2,851	$31,464	$0	$0	$0
3917	TX101688	Upper South Texas	$70,615	$413,423	$0	$0	$0
3928	x	Upper South Texas	$114,033	$0	$0	$588,021	$0
3934	x	Upper South Texas	$29,997	$0	$0	$116,745	$0
3948	x	Central	$52,038	$0	$0	$264,118	$0
4	x	High Plains	$80,413	$353,586	$11,053	$0	$201,754
4258	TX000509	Gulf Coast	$34,086	$297,508	$0	$0	$0
43	X	Metroplex	$94,143	$0	$0	$539,010	$0
44	x	Metroplex	$435,886	$395,598	$0	$842,917	$0
4449	TX001224	Upper South Texas	$102,274	$232,020	$0	$0	$0
4642	x	Upper East Texas	$67,420	$150,710	$150,709	$533,288	$0
4693	TX000504	Gulf Coast	$18,340	$251,948	$0	$0	$0
47	TX111504	Metroplex	$253,956	$795,435	$282,075	$1,040,550	$0
48	x	Metroplex	$79,609	$0	$0	$411,783	$761,117
484	TX100671	Gulf Coast	$196,129	$1,563,486	$226,026	$103,563	$216,426
493	TX100614	Gulf Coast	$397,088	$3,480,627	$454,467	$0	$0
5	TX301808	Central	$244,368	$1,765,240	$605,096	$0	$0
51	TX904403	Upper East Texas	$465,324	$2,792,512	$837,964	$376,774	$0
543	x	Gulf Coast	$193,957	$0	$0	$797,957	$0
5498	TX000505	Central	$8,782	$76,404	$0	$0	$0
56	x	Upper East Texas	$288,231	$298,543	$0	$443,301	$0
5628	TX001202	Central	$186,907	$2,775,940	$99,552	$0	$0
5727	TX000502	Gulf Coast	$84,836	$333,439	$0	$0	$0
59	TX121636	Upper Rio Grande	$30,135	$8,349	$0	$76,892	$0
593	TX101471	Lower South Texas	$40,498	$182,768	$75,760	$0	$0
6	TX902811	Northwest Texas	$408,245	$1,674,389	$342,927	$187,996	$0
6212	x	West Texas	$0	$0	$0	$266,393	$0
65	TX302962	West Texas	$183,321	$1,070,846	$191,257	$44,146	$0
6511	TX001343	Lower South Texas	$70,197	$384,240	$0	$0	$0
68	TX904007	West Texas	$79,657	$426,751	$137,473	$104,264	$0
696	TX112676	Upper South Texas	$72,333	$239,791	$0	$157,709	$0
70	x	Central	$158,176	$113,101	$0	$396,289	$0
77	x	Central	$53,984	$0	$0	$360,383	$0
8258	TX118138	Gulf Coast	$42,905	$217,504	$0	$0	$0
83	x	Central	$9,197	$0	$0	$126,581	$0

858	TX302947	Metroplex	$94,155	$549,156	$0	$0	$0
881	x	Metroplex	$88,169	$0	$0	$544,579	$0
9	TX909675	Metroplex	$663,365	$3,015,424	$508,901	$0	$853,278
90	TX000508	Central	$7,379	$74,054	$0	$0	$0
901	x	Upper Rio Grande	$6,442	$0	$0	$298,538	$0
9452	x	Statewide (optional)	$0	$251,209	$0	$0	$0
9456	x	Statewide (optional)	$3,250,000	$0	$0	$0	$0
95	TX104574	Southeast Texas	$1,104,847	$4,157,425	$36,716	$1,232,353	$159,010
9817	x	West Texas	$17,224	$0	$0	$100,390	$0
9862	x	Metroplex	$0	$13,173,467	$895,230	$0	$0
99	x	Gulf Coast	$741,078	$1,165,443	$668,259	$1,330,313	$0
Totals:			**$21,588,915**	**$85,765,073**	**$15,140,930**	**$34,388,196**	**$6,774,380**

- Foot Notes

Expenditures for the following providers were added together under one provider ID because the form does not allow more than one entry for a specific ID:

Provider ID 51/I-SATS ID TX904403 = Northeast Texas Council on Alcohol and Drug Abuse in Sabine Valley/Sabine Valley Center
Provider ID 3700/I-SATS ID TX121362 = Phoenix Houses of Texas/Phoenix Houses of Texas, Inc.
Provider ID 4642/I-SATS ID X = City of Longview/Longview Wellness Center

PROVIDER ADDRESS TABLE

State: Texas

Provider ID	Description	Provider Address
1030	36th Judicial District Juvenile Probatio	P. O. Box 1122 Sinton, TX 78387
10431	Housing Authority of the City of El Paso	5300 E. Paisano Drive El Paso, TX 79905
10432	El Paso County Hospital District dba R.E. Thomason General Hospital	4815 Alameda Avenue 8th Floor, Suite A 8th Floor, Suite A El Paso, TX 79905
10485	Community Action Council of South Texas	P. O. Drawer 98 Rio Grande City, TX 78582
10497	The Lord's Pantry of Leon County	P. O. Box 1591 Buffalo, TX 75831
106	Bay Area Council on Drugs and Alcohol	1300-A Bay Area Blvd. Suite 102 Suite 102 Houston, TX 77058
1077	Communities In Schools - Corpus Christi	3502-1/2 Greenwood P. O. Box 331203 P. O. Box 331203 Corpus Christi, TX 78416
1122	Texas A & M University Research Foundation	[NO ADDRESS PROVIDED]
11500	Your Health Clinic-AIDS Resource Center of Texoma	222 W. Brockett Sherman, TX 75090
117	San Antonio Co on Alcohol and Drug Abuse	1222 North Main Ste. 660 Ste. 660 San Antonio, TX 78212
12135	University of Texas Southwestern Medical	[NO ADDRESS PROVIDED]
131	Susbstance Abuse Council	201 S. Travis Sherman, TX 75090
1316	Family Violence Prevention Services Inc	7911 Broadway San Antonio, TX 78209
1567	Reach Midlothian Inc	P. O. Box 598 Midlothian, TX 76065
1810	Family Service Assoc of San Antonio	702 San Pedro San Antonio, TX 78212
1842	Promise House Inc	224 W. Page Street Dallas, TX 75208
2	Workers Assistance Program Inc	2525 Wallingwood Drive Bldg. #5 Bldg. #5 Austin, TX 78746
228	Abilene Regional COADA Inc	104 Pine Street Suite 210 Suite 210 Abilene, TX 79601
2508	Southwest Texas State University	350 N. Guadalupe #140, PMB 164 #140, PMB 164 San Marcos, TX 78666
		100 Independence Place

255	Sisters Communities COADA	Suite 414 Suite 414 Tyler, TX 75701
2624	Permian Basin Reg COADA	1101 N. Whitaker Odessa, TX 799763
2686	Families Under Urban Social Attack Inc	P. O. Box 88107 Houston, TX 77288
2698	Tarrant County Hospital District	1500 S. Main Street Fort Worth, TX 76104
2726	Henderson County United	309 Royall Street Athens, TX 75751
2866	Child and Family Guidance Centers	8915 Harry Hines Blvd. Dallas, TX 75235
293	Texas Commission Deaf & Hard of Hearing	P. O. Box 12904 Austin, TX 78711
2974	Drug Prevention Resources Inc	1200 Walnut Hill Lane Suite 2100 Suite 2100 Irving, TX 75038 972-518-1821
3040	Boys and Girls Clubs of Greater Ft Worth	3218 E. Belknap Fort Worth, TX 76111
3184	Comal County Family Violence Shelter Inc	P. O. Box 310344 New Braunfels, TX 78131
3387	East Dallas Counseling Center Inc	4144 North Central Expressway Suite 530 Suite 530 Dallas, TX 75204
3397	Valley AIDS Council	418 E. Tyler Suite B Suite B Harlingen, TX 78550
344	Chicano Family Center Inc	7524 Avenue E Houston, TX 77012
3447	Youth Advocates Inc	P. O. Box 230192 Houston, TX 77223
3455	Cameron Co Task Force on Redu Teen Preg	806 Morgan Blvd. Suite B Suite B Harlingen, TX 78550
3512	Family Support Services	1001 S. Polk Amarillo, TX 79101
3544	Quad Counties COADA	902 S. Main Street Suite C Suite C Del Rio, TX 78840
359	West Dallas Community Centers Inc	8200 Brookriver Suite N-704 Suite N-704 Dallas, TX 75247
3605	Special Health Resources of East Texas	P. O. Box 2709 Longview, TX 75606
3660	Girls Inc of Tarrant County	2820 Matlock Rd. Arlington, TX 76015
3663	Viable Options in Community Endeavors	P. O. Box 687 Corsicana, TX 75151
3679	Coastal Bend AIDS Foundation	400 Mann Street Suite 800 Suite 800 Corpus Christi, TX 78401
3692	Community Clinic Inc	203 W. Olmos Suite 300 Suite 300 San Antonio, TX 78212

3695	UT Southwestern Medical Center at Dallas	2330 Butler Street Suite 103 Suite 103 Dallas, TX 75235
3778	Bluebonnet Trails Community MHMR Center	1009 North Georgetown Street Round Rock, TX 78664
3810	Santa Fe Adolescent Service Inc	7524 Mosier View Court Suite 200 Suite 200 Fort Worth, TX 76118
3890	Peacemakers Unlimited	508 Twilight Trail Suite 99 Suite 99 Richardson, TX 75080
3928	Joven Juvenile Outreach Vocational Educ	102 W. White Street San Antonio, TX 78214
3934	Karnes Wilson Juvenile Board	101 N. Panna Maria Avenue Suite 3 Suite 3 Karnes City, TX 78118
3948	Youth and Family Alliance	1221 W. Ben White Blvd. #108A #108A Austin, TX 78704
4	Amarillo Council on Alcohol Drug Abuse	803 S. Rusk Amarillo, TX 79108
43	Rainbow Days Inc	8150 N. Central Expressway, Ste. 1600 Dallas, TX 75206 214-887-0726
44	Tarrant Council on Alcohol Drug Abuse	2700 A Freeway Fort Worth, TX 76111
4642	Longview Wellness Center Inc	1107 East Marshall Avenue Longview, TX 75601
48	Greater Dallas COADA	4525 Lemmon Avenue Suite 300 Suite 300 Dallas, TX 75219
543	Family Service Center	3815 Montrose Blvd. Suite 200 Suite 200 Houston, TX 77006
56	East Texas Council Alcohol Drug Abuse	708 Glencrest Lane Longview, TX 75601
6212	RY Team-N-Texas	P. O. Box 14765 Odessa, TX 79768
70	Heart of TX Co on Alcohol and Drug Abuse	900 Austin Avenue #801 #801 Waco, TX 76701
77	Williamson County COADA	P. O. Box 1279 Georgetown, TX 78627
83	YWCA of Greater Austin	2015 South IH35 Suite 110 Suite 110 Austin, TX 78741
881	Dallas Challenge Inc	7777 Forest Lane B-410 B-410 Dallas, TX 75230
901	Communities In Schools El Paso	1401 Pendale El paso, TX 79936
9452	University of Texas - Austin	[NO ADDRESS PROVIDED]
9456	Texas Department of	P. O. Box 99

	Criminal Justice	Huntsville, TX 77342
9817	Palmer Drug Abuse Program	1201 West Texas Avenue midland, TX 79701
9862	Value Behavioral Health of Texas, Inc.	1199 South Belt Line Suite 100 Suite 100 Coppell, TX 75019
99	Houston CODADA	303 Jackson Hill Houston, TX 77007

Form 6a

State: Texas

Prevention Strategy Report

Column A (Risks)	Column B(Strategies)	Column C (Providers)
Children of Substance Abusers [1]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Brochures [4]	0
	Radio and TV public service announcements [5]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Peer leader/helper programs [13]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Preschool ATOD prevention programs [16]	0
	Drug free dances and parties [21]	0
	Youth/adult leadership activities [22]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	See footnotes [34]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Accessing services and funding [45]	0
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	0
	Modifying alcohol and tobacco advertising pratices [53]	0
Pregnant Women/Teens [2]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Media campaigns [3]	0
	Brochures [4]	0
	Radio and TV public service announcements [5]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0

	Preschool ATOD prevention programs [16]	0
	Drug free dances and parties [21]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	See footnotes [34]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Accessing services and funding [45]	0
	Modifying alcohol and tobacco advertising pratices [53]	0
Drop-Outs [3]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Media campaigns [3]	0
	Brochures [4]	0
	Radio and TV public service announcements [5]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Ongoing classroom and/or small group sessions [12]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Drug free dances and parties [21]	0
	Community drop-in centers [23]	0
	Recreation activities [26]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Accessing services and funding [45]	0
	Modifying alcohol and tobacco advertising pratices [53]	0
Violent and Delinquent Behavior [4]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Media campaigns [3]	0
	Brochures [4]	0
	Radio and TV public service announcements [5]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0

	Drug free dances and parties [21]	0
	Youth/adult leadership activities [22]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	See footnotes [34]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Accessing services and funding [45]	0
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	0
	Modifying alcohol and tobacco advertising pratices [53]	0
Economically Disadvantaged [6]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Media campaigns [3]	0
	Brochures [4]	0
	Radio and TV public service announcements [5]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Peer leader/helper programs [13]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Preschool ATOD prevention programs [16]	0
	Drug free dances and parties [21]	0
	Youth/adult leadership activities [22]	0
	Community drop-in centers [23]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	See footnotes [34]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Accessing services and funding [45]	0
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	0
	Modifying alcohol and tobacco advertising pratices [53]	0
Already Using Substances [9]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Media campaigns [3]	0

	Brochures [4]	0
	Radio and TV public service announcements [5]	0
	Speaking engagements [6]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Peer leader/helper programs [13]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Drug free dances and parties [21]	0
	Youth/adult leadership activities [22]	0
	Community drop-in centers [23]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	See footnotes [34]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Accessing services and funding [45]	0
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	0
	Modifying alcohol and tobacco advertising pratices [53]	0
Homeless and/or Run away Youth [10]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Media campaigns [3]	0
	Brochures [4]	0
	Radio and TV public service announcements [5]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Drug free dances and parties [21]	0
	Youth/adult leadership activities [22]	0
	Community drop-in centers [23]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	See footnotes [34]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0

	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Accessing services and funding [45]	0
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	0
	Modifying alcohol and tobacco advertising pratices [53]	0

- Foot Notes

Code 34 (Other, Specify) Problem Identification and Referral: This strategy is provided through indicated prevention programs for individual participants who are showing early warning signs of substance use or abuse and/or exhibiting other high risk problem behaviors. Strategies include identification of those who have indulged in illegal use of tobacco or alcohol and those individuals who have indulged in first use of illicit drugs in order to assess if their behavior can be reversed through education. Referrals for substance abuse screening and assessment and other needed services are made as appropriate. Follow-up is conducted to determine if the participant has accessed the service. This strategy does not include any activity designed to determine if a person is in need of treatment.

Form 7a

TREATMENT UTILIZATION MATRIX

State: Texas

Dates of State Expenditure Period: From: 9/1/2005 To: 8/31/2006

Level of Care	Number of Admissions ≥ Number of Persons		Costs per Person		
	A.Number of Admissions	B.Number of Persons	C.Mean Cost of Services per Person	D.Median Cost of Services per Person	E.Standard Deviation of Cost per Person
Detoxification (24-Hour Care)					
Hospital Inpatient (Detox)	1251	1162	$ 773.62	$ 700	$ 288.12
Free-standing Residential	7554	6744	$ 721.69	$ 700	$ 326.41
Rehabilitation / Residential					
Hospital Inpatient (Rehabilitation)	36	36	$ 2258.89	$ 1932	$ 1542.86
Short-term (up to 30 days)	13232	11807	$ 1401.94	$ 1311	$ 921.71
Long-term (over 30 days)	4238	3916	$ 5263.90	$ 3700	$ 4369.51
Ambulatory (Outpatient)					
Outpatient	17485	16504	$ 606.87	$ 442	$ 592.18
Intensive Outpatient	10956	10458	$ 1099.57	$ 918	$ 958.35
Detoxification	1853	1691	$ 540.39	$ 510	$ 423.52
Opioid Replacement Therapy (ORT)					
Opioid Replacement Therapy	2299	2206	$ 3675.95	$ 2650	$ 3256.31

Form 7b

Number of Persons Served (Unduplicated Count) for alcohol and other drug use in state-funded services by age, sex, and race/ethnicity

State: Texas

Age	A. Total	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic or Latino		J. Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	5874	1007	445	795	130	1	1	17	2	12	6	22	9	2567	860	1902	621	2519	832
2. 18-24	9038	2253	2107	693	482	4	2	33	10	17	19	11	11	1982	1414	3223	2837	1770	1208
3. 25-44	24994	6441	5779	2545	1778	11	7	48	33	62	71	38	23	4747	3411	10175	8676	3817	2426
4. 45-64	8403	2508	1414	1504	672	4	1	10	2	41	21	15	8	1516	687	4560	2496	1038	309
5. 65 and over	115	29	15	25	2	0	0	0	0	2	0	0	1	36	5	64	21	28	2
6. Total	48424	12238	9760	5562	3064	20	11	108	47	134	117	86	52	10848	6377	19924	14651	9172	4777
7. Pregnant Women	820		385		135		1		3		4		4		288		530		290

Did the values reported by your State on Forms 7a and 7b come from a client-based system(s) with unique client identifiers? (•) Yes ( ) No

Numbers of Persons Served who were admitted in a period prior to the 12 month reporting period. 11221

Texas
Description of Calculations

Description of Calculations

If revisions or changes are necessary to prior years' description of the following, please provide: a brief narrative describing the amounts and methods used to calculate the following: (a) the base for services to pregnant women and women with dependent children as required by 42 U.S.C. 300x-22(b)(1); and, for 1994 and subsequent fiscal years report the Federal and State expenditures for such services; (b) the base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. 300x-24(d); and, (c) for designated States, the base and MOE for HIV early intervention services as required by 42 U.S.C. 300x-24(d) (See 45 C.F.R. 96.122(f)(5)(ii)(A)(B)(C)).

State: Texas

Calculation of Maintenance of Effort (MOE) Tables.

Table II: Tuberculosis Services

The tuberculosis base was established by using the 1991-1992 state expenditures for TB services to substance abusers by the Texas Department of Department of State Health Services (DSHS), formerly the Texas Department of Health (TDH). The base figure is $868,499.

To calculate the amount of state funds spent on TB patients with substance abuse, the number of TB patients with a substance abuse disorder is divided by the number of reported TB patients less the number of TB patients reported at death. The result is the percentage of living TB patients with substance abuse. This percentage is applied to the total state funds expended on TB services for all persons. For SFY 2008, DSHS used the reported state expenditures of $12,400,326 and applied the percentage of reported substance abuse clients (24.5089%) to determine the amount of state funds spent on clients who were substance abusers in treatment, totaling $3,039,182.

Table III: HIV Early Intervention Services

The maintenance of effort (MOE) for HIV consists of all non-Federal funds spent on early intervention services for HIV provided to substance abusers in treatment at the site at which they received substance abuse treatment during the state fiscal year.

The MOE for HIV early intervention services was calculated based upon expenditures for outreach services funded by the former Texas Department of Health (TDH), now a part of the Texas Department of State Health Services (DSHS), compared to the TB base established by state expenditures by TDH for HIV early intervention services in 1991-1992. The MOE base was calculated by using the 1991-1992 state expenditures for HIV services provided to substance abusers in treatment as the average of TDH (now part of DSHS) expenditures in SFY 1991 and SFY 1992, $54,000 and $67,000 respectively, creating a base figure of $60,500.

By using the most recent AIDS case data of July 1, 2008, only adult AIDS cases (more than 12 years old) are selected for analysis. A frequency of mode (method) of exposure results in the number of cases and percent of the selected cases each mode represents. The percentages for Injecting Drug Use and Male-Male Sex-Injecting Drug Use are added together to provide the total percent of eligible cases in which injecting drug use is a risk. This percentage (23.34%) was applied to the expenditures from the HIV Early Intervention Programs, HIV State Services Programs, and Ryan White Programs to calculate the total of all state

funds spent on early intervention services for HIV. Based on annualized expenditures, it is projected that total state funds in the amount of $3,797,184 will be spent on HEI in SFY 2008.

Table IV: Pregnant Women and Women with Dependent Children

On June 29, 1995, the Texas Commission on Alcohol and Drug Abuse (TCADA), now part of the Department of State Health Services (DSHS) issued an official interpretation of the Women's base requirement to CSAT. As a result of such action, the Women's base was established utilizing the 1992 requirement of $6,720,580. For 1993, the Women's base requirement was equal to the 1992 requirement plus 5 percent of the 1993 Block Grant ($6,720,580 + $3,508,233) for a total of $10,228,813. For 1994, the Women's base requirement was equal to the 1993 base plus 5 percent of the 1994 Block Grant ($10,228,813 + $3,759,080), yielding a total of $13,987,893.

The FY 2008 total amount of projected expenditures for direct services to pregnant women and women with dependent children is $19,780,319, which is $19,780,319 in Federal Block Grant funds paid to contracted entities throughout the State. This exceeds the federal set aside requirement of $13,987,893, and excludes administrative and/or program support costs. The finalized expenditures will be provided in the FFY 2011 SAPT Block Grant Application.

SSA (MOE TABLE I)

State: Texas

Total Single State Agency (SSA) Expenditures for Substance Abuse (Table I)

PERIOD (A)	EXPENDITURES (B)	B1(2006) + B2(2007) / 2 (C)
SFY 2006 (1)	**$24,350,513**	**$24,508,188**
SFY 2007 (2)	**$24,665,863**	
SFY 2008 (3)	$ 24,580,935	

Are the expenditure amounts reported in Column B "actual" expenditures for the State fiscal years involved?

FY 2006 (•) Yes ( ) No

FY 2007 (•) Yes ( ) No

FY 2008 ( ) Yes (•) No

If estimated expenditures are provided, please indicate when "actual" expenditure data will be submitted to SAMHSA (mm/dd/yyyy): 9/1/2009

The MOE for State fiscal year(SFY) 2008 is met if the amount in Box B3 is greater than or equal to the amount in Box C2 assuming the State complied with MOE Requirements in these previous years.

The State may request an exclusion of certain non-recurring expenditures for a singular purpose from the calculation of the MOE, provided it meets CSAT approval based on review of the following information:

Did the State have any non-recurring expenditures for a specific purpose which were not included in the MOE calculation?

( ) Yes (•) No If yes, specify the amount and the State fiscal year: $, (SFY)

Did the State include these funds in previous year MOE calculations?

(•) Yes ( ) No

When did the State submit an official request to the SAMHSA Administrator to exclude these funds from the MOE calculations? (Date)

TB (MOE TABLE II)

State: Texas

Statewide Non-Federal Expenditures for Tuberculosis Services to Substance Abusers in Treatment (Table II)

(BASE TABLE)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment A X B (C)	Average of Columns C1 and C2 C1 + C2 -------- 2 (D)
SFY 1991 (1)	**$ 8,862,234**	**9.80 %**	**$ 868,499**	**$ 868,499**
SFY 1992 (2)	**$ 8,862,234**	**9.80 %**	**$ 868,499**	

(MAINTENANCE TABLE)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment A X B (C)
SFY 2008 (3)	**$ 12,400,326**	**24.5089 %**	**$ 3,039,183**

HIV (MOE TABLE III)

State: Texas

Statewide Non-Federal Expenditures for HIV Early Intervention Services to Substance Abusers in Treatment (Table III)

(BASE TABLE)

Period	Total of All State Funds Spent on Early Intervention Services for HIV (A)	Average of Columns A1 and A2 A1 + A2 -------- 2 (B)
SFY 1991 (1)	$ 54,000	$ 60,500
SFY 1992 (2)	$ 67,000	

(MAINTENANCE TABLE)

Period	Total of All State Funds Spent on Early Intervention Services for HIV* (A)
SFY 2008 (3)	$ 3,797,184

* Provided to substance abusers at the site at which they receive substance abuse treatment

Womens (MOE TABLE IV)

State: Texas

Expenditures for Services to Pregnant Women and Women with Dependent Children (Table IV)

(MAINTENANCE TABLE)

Period	Total Women's Base (A)	Total Expenditures (B)
1994	**$13,987,893**	
2006		**$16,309,049**
2007		**$18,871,933**
2008		$ 19,780,319

Enter the amount the State plans to expend in FY 2009 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A {1994}): $ 13,987,893

Texas
1. Planning

1. Planning
This item addresses compliance of the State's planning procedures with several statutory requirements. It requires completion of narratives and a checklist.

These are the statutory requirements:

- 42 U.S.C. 300x-29, 45 C.F.R. 96.133 and 45 C.F.R. 96.122(g)(13) require the State to submit a Statewide assessment of need for both treatment and prevention.

In a narrative of **up to three pages**, describe how your State carries out sub-State area planning and determines which areas have the highest incidence, prevalence, and greatest need. Include a definition of your State's sub-State planning areas. Identify what data is collected, how it is collected, and how it is used in making these decisions. If there is a State, regional, or local advisory council, describe their composition and their role in the planning process. Describe the monitoring process the State will use to assure that funded programs serve communities with the highest prevalence and need. Those States that have a State Epidemiological Workgroup or a State Epidemiological Outcomes Workgroup, must describe its composition and its contribution to needs assessment, planning, and evaluation processes for primary prevention and treatment planning. States are encouraged to utilize the epidemiological analyses and profiles to establish substance abuse prevention and treatment goals at the State level.

- 42 U.S.C. 300x-51 and 45 C.F.R. 96.123(a)(13) require the State to make the State plan public in such a manner as to facilitate public comment from any person during the development of the plan.

In a narrative of **up to two pages**, describe the process your State used to facilitate public comment in developing the State's plan and its FY 2009 application for SAPT Block Grant funds.

Planning

The Planning Process

The Texas Department of State Health Services (DSHS), which combines its precursor agencies responsible for public health, mental health and substance abuse prevention and treatment services, has conducted approximately 40 different surveys through dedicated funding from the State Treatment Needs Assessment Program and the Prevention Needs Assessment Program since 1988. These surveys provide data on adults in the general population, elementary and secondary school students; the adult and juvenile justice systems, college students, Texans living on the Mexico border, and parents and their children. These surveys and other national survey data assist the state agency in identifying areas of need and provide overall information for the planning process.

The Texas Survey of Substance Use Among Adults has been used to assess the needs of adults in treatment services since 2000. However, because this survey has been discontinued, the state estimates from the multiple-year data of 2003-2006 National Survey on Drug Use and Health (NSDUH) are used to access adult treatment needs in Texas for 2006. This national survey, conducted annually by the Office of Applied Studies (OAS) at the Substance Abuse and Mental Health Services Administration (SAMHSA), uses in-person interviews to collect data that produces drug and alcohol use incidence and prevalence estimates. Survey data are also collected periodically on special topics of interest such as serious mental illness, criminal behaviors, substance abuse treatment, and attitudes about drugs. The state estimates for adult treatment needs are based on a sample of 9,537 Texans age 18 and over in the 2003-2006 NSDUH. Estimates of adult treatment needs by gender, age category, and racial/ethnic group for the state as a whole and for 11 sub-state planning areas are obtained from the OAS. The 11 sub-state planning areas are defined as the 11 Texas Health and Human Services Regions (Appendix A shows the counties included in each region)

The Texas School Survey of Substance Use Among Students is used to assess prevention, intervention and treatment youth needs and has been conducted biennially since 1988. Substance use prevention, intervention and treatment youth needs are calculated using prevalence numbers from the survey and the youth population aged 12 to 17 in Texas. The 2006 School Survey, a sample of 141,905 Texas students in grades seven through twelve, is used to assess youth needs for 2006. Students are randomly selected from school districts throughout the state using a multi-stage probability design. School districts along the Texas-Mexico border are over-sampled to allow statistically valid comparison to the rest of the state. The survey asks students about the use of tobacco, alcohol, inhalants, dextromethorphan, codeine cough syrup, marijuana, and other illicit drugs. Other questions pertain to the behavioral and demographic correlates of substance abuse, including risk and protective factors, sources of information about substance-related problems, perceptions of peer values and attitudes, and the perceived safety of the home, neighborhood, and school environment.

The estimated need for prevention services for universal, selective, and indicated populations at the state and sub-state level have been calculated by applying parameters derived from responses to the statewide school survey. These estimates are used to guide programming decisions in prevention, and providers are expected to identify and serve these populations appropriately. All Texas youth are included in the universal prevention population. Youth are defined as needing selective prevention if they were at risk in their environments (including youths who feel unsafe at school/home/neighborhood, have all/most of peers who carry weapons, drop out of school or

belong to a gang, have no peers who feel close to their parents or care about good grades, perceived parents' approval of using beer/marijuana, perceived no/less danger of using marijuana, or perceived easy availability of marijuana). Youth are defined as in need of indicated prevention if they were at high risk in their environments (including youths who have used any substance during the past school year plus had at least one alcohol- or drug-related social problem during the past school year such as attending class while under the influence of drugs, driving while under the influence of drugs, or getting into trouble with teachers/police/peers/dates due to substance use).

The state estimates of NSDUH and the prevalence numbers from the Texas School Survey are currently used to estimate the number of persons in need of services at the state and sub-state levels. Additionally, as the results of other surveys and synthetic estimates become available, need estimates are developed for special populations and high-risk groups served by DSHS. The data-driven need estimates help guide planning decisions, identify substance abuse service gaps, and allocation of funds. To ensure that this data and other quantitative information is used in allocating funds, the Texas legislature enacted Section 461.0124, *Texas Health and Safety Code* in 1997, which required TCADA (and now DSHS) to develop a service funding process that ensures equity in the availability of chemical dependency services across the state and within each of the 11 health and human service regions established under Section 531.024, *Texas Government Code*. These need estimates are factored into the funding formula described below.

Funding Allocation Formula

DSHS is committed to maintaining a system that promotes reasonable access to services by individuals in need throughout the state. As such, DSHS continues to allocate funds through a system that ensures a stable service environment, and one that produces equity in funding across and within all regions of the state. To address this priority and guide funding allocation decisions across the state's regions and subregions, DSHS uses a funding formula that was revised by TCADA in 2001, and is reviewed annually by the DSHS-MHSA leadership to ensure continued applicability as population changes occur over time. The revised formula was adopted by the TCADA governing board to better define and weigh the impact of changes on the existing service delivery system, to include three factors listed in order of weighted priority: 1) population; 2) poverty; and 3) need.

Population is the most heavily weighted factor, representing 75 percent of the total formula; poverty represents 20 percent of the formula and need is 5 percent. Funding decisions will continue to be guided by this formula as new or underutilized funding becomes available.

DSHS's rules for funded programs (Chapter 144.411 and 144.511) require every funded program to specify its target population, to develop strategies and activities that are appropriate to the target population and to report on a monthly basis on its performance and activity measures defined for the target population. Licensure guidelines, capacity management and waiting lists enable DSHS to monitor the capacity of programs and levels of utilization. Noncompliance with the rules for funded programs can lead to sanctions by DSHS.

State Epidemiological Workgroup

The Texas Epidemiological Workgroup (TEW) was established in 2004 as part of the state prevention framework funded through the State Prevention Framework State Incentive Grant (SPF SIG). The TEW meets periodically and is comprised of representatives from the various state agencies that collect information regarding the consumption and consequences of substance

abuse and related intervening/causal factors. The group also includes evaluation team members, entities representing underage drinking such as Texans Standing Tall and the Texas Alcoholic Beverage Commission, and community representatives. TEW participants overlap, in part, with the membership of the SPF SIG Advisory Committee. TEW has provided necessary information and support to the Advisory Committee and prevention coalitions to inform the selection of community sites and input on changes in selected indicators.

The TEW's role is to support the state's prevention infrastructure management and guide planning decisions. The TEW assists the state in its capacity to collect, analyze and report data to promote data-driven decision-making in each step of the strategic prevention framework. The TEW also assists the state in conducting a more precise analysis of prevention service delivery gaps in substance abuse and across mental health, education, criminal justice and other prevention systems.

Definition of 11 Sub-state Planning Areas in Texas

Region	Counties Serviced
Region 1: High Plains	Armstrong, Bailey, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Crosby, Dallam, Deaf Smith, Dickens, Donley, Floyd, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchinson, King, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher, Terry, Wheeler, Yoakum
Region 2: Northwest Texas	Archer, Baylor, Brown, Callahan, Clay, Coleman, Comanche, Cottle, Eastland, Fisher, Foard, Hardeman, Haskell, Jack, Jones, Kent, Knox, Mitchell, Montague, Nolan, Runnels, Scurry, Shackelford, Stonewall, Stephens, Taylor, Throckmorton, Wichita, Wilbarger, Young
Region 3: Metroplex	Collin, Cooke, Dallas, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, Wise
Region 4: Upper East Texas	Anderson, Bowie, Camp, Cass, Cherokee, Delta, Franklin, Gregg, Harrison, Henderson, Hopkins, Lamar, Marion, Morris, Panola, Rains, Red River, Rusk, Smith, Titus, Upshur, Van Zandt, Wood
Region 5: Southeast Texas	Angelina, Hardin, Houston, Jasper, Jefferson, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Shelby, Trinity, Tyler

Region 6: Gulf Coast	Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Harris, Liberty, Matagorda, Montgomery, Walker, Waller, Wharton
Region 7: Central Texas	Bastrop, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Coryell, Falls, Fayette, Freest 1, Grimes, Hamilton, Hays, Hill, Lampasas, Lee, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Travis, Washington, Williamson
Region 8: Upper South Texas	Atacosa, Bandera, Bexar, Calhoun, Comal, DeWitt, Dimmit, Edwards, Frio, Gillespie, Goliad, Gonzales, Guadalupe, Jackson, Karnes, Kendall, Kerr, Kinney, La Salle, Lavaca, Maverick, Medina, Real, Uvalde, Val Verde, Victoria, Wilson, Zavala
Region 9: West Texas	Andrews, Borden, Coke, Concho, Crane, Crockett, Dawson, Ector, Gaines, Glasscock, Howard, Irion, Kimble, Loving, Martin, Mason, McCulloch, Menard, Midland, Pecos, Reagan, Reeves, Schleicher, Sterling, Sutton, Terrell, Tom Green, Upton, Ward, Winkler
Region 10: Upper Rio Grande	Brewster, Culberson, El Paso, Hudspeth, Jeff Davis, Presidio
Region 11: Lower South Texas	Aransas, Bee, Brooks, Cameron, Duval, Hidalgo, Jim Hogg, Jim Wells, Kenedy, Kleberg, Live Oak, McMullen, Nueces, Refugio, San Patricio, Starr, Webb, Willacy, Zapata

Facilitation of Public Comment (SAPTBG)

An item was published in the Texas Register announcing the Department of State Health Services (DSHS) intention to submit a State Plan. Directions regarding how and when to obtain a draft of the plan were included in the announcement. The draft plan was made available electronically, or by mail upon request on the DSHS website. An electronic mailbox was established specifically to receive comments on the plan. The published announcement included the electronic address, as well as a mailing address for submission of comments.

Stakeholders and other interested persons who regularly receive announcements of any updates on the substance abuse page were contacted via e-mail regarding the availability of the plan and opportunity to make comments. Over 1,050 persons were specifically notified by e-mail.

The specific stakeholders that were targeted for input about the substance abuse service delivery system and the SAPT Block Grant application include but are not limited to the legislatively-mandated Drug Demand Reduction Advisory Committee (DDRAC), the federally-required State Incentive Grant Advisory Committee and professional groups and associations such as the

Association of Substance Abuse Programs (ASAP). These groups are instrumental to the development of the continuation SAPT Block Grant application and in assisting DSHS in identifying key areas where improvements should be implemented. Input from these organizations ensures continued community and public input and assists DSHS in identifying and assessing regional needs for substance abuse services.

Additionally, a session was conducted at the annual statewide Tobacco Conference in Houston in July, 2008 to provide information and obtain public input for the development of the FY09 SAPT BG application and Synar Report.

Planning Checklist

State: Texas

Criteria for Allocating Funds

Use the following checklist to indicate the criteria your State will use how to allocate FY 2009 Block Grant funds. Mark all criteria that apply. Indicate the priority of the criteria by placing numbers in the boxes. For example, if the most important criterion is 'incidence and prevalence levels', put a '1' in the box beside that option. If two or more criteria are equal, assign them the same number.

1 Population levels, Specify formula:

75%, Regional population as a percent of total population

3 Incidence and prevalence levels

Problem levels as estimated by alcohol/drug-related crime statistics

Problem levels as estimated by alcohol/drug-related health statistics

Problem levels as estimated by social indicator data

Problem levels as estimated by expert opinion

Resource levels as determined by (specify method)

Size of gaps between resources (as measured by)

and needs (as estimated by)

2 Other (specify method)

20% Poverty, Indigency as a percent of regional population

- Foot Notes

The formula equals .75 x population + .20 x Poverty + .05 x Prevalence (Need).

See Planning Narrative in this application.

Form 8

State: Texas

Treatment Needs Assessment Summary Matrix

Calendar Year: 2006

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: 0	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
High Plains	817616	84545	1284	21326	324	28339	1456	4584	5374	0	2	3	3

Calendar Year: 2006

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: 0	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Northwest Texas	554668	43217	465	13267	143	17449	891	2134	3740	0	4	6	2

Calendar Year: 2006

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: 0	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Metroplex	6302776	444265	19802	76549	3412	160535	8439	19394	30752	0	6	14	7

Calendar Year: 2006

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related	C. Other: 0	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000

									arrests				
Upper East Texas	1072677	66228	3348	17062	862	16113	2662	4760	7156	0	3	7	5

Calendar Year: 2006

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: 0	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Southeast Texas	763516	48770	3539	5658	411	18397	908	2442	5957	0	2	5	3

Calendar Year: 2006

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: 0	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Gulf Coast	5497488	464588	16804	39660	1434	146070	2166	16370	37656	0	1	20	8

Calendar Year: 2006

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: 0	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Central	2614374	233216	11277	40529	1960	80555	3161	14602	12510	0	2	9	3

Calendar Year: 2006

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: 0	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Upper South													

Texas	2362899	202535	5593	52984	1463	55419	2890	13713	20907	0	7	10	7

Calendar Year: 2006

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: 0	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
West Texas	542801	32531	849	7295	190	12531	467	3007	4321	0	2	4	3

Calendar Year: 2006

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: 0	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Upper Rio Grande	762908	46724	8163	8889	1553	17195	1507	3502	3552	0	2	5	10

Calendar Year: 2006

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: 0	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Lower South Texas	1996146	137287	3955	26011	749	32023	3106	9574	11833	0	3	7	11

Calendar Year: 2006

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: 0	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
State Total	23287869	1803906	75078	309229	12502	584626	27654	94082	143758	0	4	13	7

- Foot Notes

Sources: 1. 2006 Population Projections for Texas, Texas State Data Center and Texas Health and Human Services Commission, Oct. 2006 version. 2. 2003-2006 National Survey on Drug Use and Health for Texas, Office of Applied Studies/SAMHSA, June 2008. 3. 2006 Texas School Survey of Substance Use Among Students in Grades 7-12, DSHS, March 2008. 4. "Secondary School Completion and Dropouts in Texas Public Schools 2005-06", Texas Education Agency, August 2007. (Dropout rates were used to adjust the C.D. rates among in-school youths.) 5. 2006 Behavioral Health Integrated Provider System (BHIPS) Client Data, DSHS. 6. 2006 Uniform Crime Reporting Arrest Data, Texas Department of Public Safety; Analyses by Decision Support Unit/DSHS. 7. Various 2006 health statistics (AIDS, TB, and Hepatitis B), DSHS.

Form 9

State: Texas

Substate Planning Area [95]: State Total

Treatment Needs by Age, Sex, and Race/ Ethnicity

AGE GROUP	A. Total	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic Or Latino		J. Hispanic Or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
17 Years Old and Under	190,116	41,842	26,507	14,511	7,680									62,692	36,884	58,916	35,885	60,129	35,186
18 - 24 Years Old	491,226	143,532	115,025	32,073	9,805									126,544	64,247	180,336	131,453	121,814	57,624
25 - 44 Years Old	768,415	219,427	113,833	65,895	35,848									278,105	55,307	287,501	162,810	275,926	42,178
45 - 64 Years Old	216,217	113,778	87,353		8,079										7,007	137,928	100,430	72,804	2,008
65 and Over	17,161		17,161																
Total	1,683,135	518,579	359,879	112,479	61,412	0	0	0	0	0	0	0	0	467,341	163,445	664,681	430,578	530,673	136,996

- Foot Notes

Data for the following categories were left blank due to low precision with no estimate reported from the 2003-2006 NSDUH:
Age Group 45-64 -- C. Black Male, H. All Other or Unknown Male;
Age Group 65 & Over -- B. White Male, C. Black Male/Female, H. All Other or Unknown Male/Female, I. Not Hispanic or Latino Male/Female, J. Hispanic or Latino Male/Female.

Sources:
1. 2006 Population Projections for Texas, Texas State Data Center and Texas Health and Human Services Commission, Oct. 2006 version.
2. 2003-2006 National Survey on Drug Use and Health (NSDUH) for Texas, Office of Applied Studies/SAMHSA, June 2008.
3. 2006 Texas School Survey of Substance Use Among Students in Grades 7-12, DSHS, March 2008.
4. "Secondary School Completion and Dropouts in Texas Public Schools 2005-06", Texas Education Agency, August 2007
(Dropout rates were used to adjust the C.D. rates among in-school youths).

Texas

How your State determined the estimates for Form 8 and Form 9

How your State determined the estimates for Form 8 and Form 9

Under 42 U.S.C. 300x-29 and 45 C.F.R. 96.133, States are required to submit annually a needs assessment. This requirement is not contingent on the receipt of Federal needs assessment resources. States are required to use the best available data. Using **up to three pages**, explain what methods your State used to estimate the numbers of people in need of substance abuse treatment services, the biases of the data, and how the State intends to improve the reliability and validity of the data. Also indicate the sources and dates or timeframes for the data used in making these estimates reported in both Forms 8 and 9. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7, Form 8.

How your State determined the estimates for Form 8 and Form 9 (BG FFY2009):

I. Estimates for Adult Treatment Needs in Texas

The state estimates from the multiple-year data of 2003-2006 National Survey on Drug Use and Health (NSDUH) were used to access adult treatment needs in Texas. The substance abuse treatment needs for adults were estimated by multiplying the adult population aged 18 and older by the percentage of those needing treatment for an alcohol or drug use problem if they met the diagnostic criteria for dependence on or abuse of alcohol or illicit drugs in the past 12 months or received specialty treatment for alcohol or illicit drug use in the past 12 months. The number of individuals who would seek treatment was based on the percentage of persons who did not receive, but felt they needed, treatment for an illicit drug or alcohol problem. The number also included persons who received treatment at a location other than a specialty facility, but felt they needed additional treatment.

The NSDUH, conducted annually by the Office of Applied Studies (OAS) at the Substance Abuse and Mental Health Services Administration (SAMHSA), uses in-person interviews to collect data from which drug and alcohol use incidence and prevalence estimates are developed. Survey data are also collected periodically on special topics of interest such as serious mental illness, criminal behaviors, substance abuse treatment, and attitudes about drugs. The state estimates for adult treatment needs were based on a sample of 9,537 Texans aged 18 and over in the 2003-2006 NSDUH. The percentage of adults needing treatment by gender, age category, and racial/ethnic group for the state as a whole and for 11 sub-state planning areas were requested and obtained from the OAS.

As one of the eight large states sampled in NSDUH, the direct survey-weighted estimates were available for Texas. The direct design-based estimates for these eight states had relatively small standard errors, so these estimates were assumed to be the "true values" for the purpose of validating the modeled estimates. To develop a good relative summary measure, the absolute value of the difference between the modeled estimate and the direct-weighted estimate for each of the eight states was divided by the direct-weighted estimate and averaged across the eight states to obtain an overall estimate of relative bias for each of the substance use measures. The overall standard errors of percentages were 0.4 percent for needing treatment prevalence and 0.07 percent for seeking treatment prevalence based on the 2003-2006 NSDUH data in Texas.

II. Estimates for Youth Treatment Needs in Texas

The statewide Texas School Survey of Substance Use Among Students (TSS) has been conducted biennially since 1988 and used to assess youth treatment needs. Youth treatment needs were calculated using the prevalence numbers from TSS and the youth population aged 12 to 17 in Texas. Since the sampling method of TSS (a multi-stage cluster approach) was not based on regional strata, the method of census-based synthetic estimation was applied to measure the youth treatment needs in sub-state planning area. The basic logic of this form of synthetic estimation is extrapolation from estimated rates of demographic groups at the state level to the same demographic groups at the small area (e.g. county) levels of analysis. The synthetic estimate for the county is then calculated as the weighted average of the state rates for each

demographic group (the weights being the relative size of each demographic group within the county). In addition, since the TSS results can be generalized only to in-school students, the fact that school dropouts may have a higher prevalence of substance use is taken into account when estimating the treatment needs of youth population in Texas.

Youths are considered to be in need of treatment if they were chemically dependent. Based on TSS questions, a proxy parameter of chemical dependence is derived. Chemical dependence is defined as using a substance (except tobacco) daily or more than once per week and having had any of the following problems during the past school year: attended class high, gotten into trouble with teachers or police due to substance use, had difficulties with friends or dates due to substances, or driven while high on substances.

The 2006 TSS data was used to estimate the 2006 youth treatment needs. This survey included a sample of 141,905 Texas students in grades seven through twelve. Students were randomly selected from school districts throughout the state using a multi-stage probability design. Stage one was the selection of districts; stage two, the selection of classes within the sampled districts; and stage three, the selection of classes within the sampled schools. School districts along the Texas-Mexico border were over-sampled to allow statistically-valid comparison to the rest of the state. The survey asks students about the use of tobacco, alcohol, inhalants, and illicit drugs. Other questions pertain to the behavioral and demographic correlates of substance abuse, including risk and protective factors, sources of information about substance-related problems, and perceptions of peer values and attitudes. The TSS was a joint project of Texas Department of State Health Services (DSHS) with the Public Policy Research Institute at Texas A&M University.

The TSS is compatible with the national Monitoring the Future Survey. To ensure the quality of the statewide survey data, a number of internal checks were put into place to guide the process. First, a quality control analyst oversaw the implementation of all pre- and post-analysis quality control procedures -- from the initial mailing through the production of the final report. Also, the litho-coding is used to confirm that data from every survey instrument read was associated with the correct school district. Programming checks were also incorporated into the data analysis program by cross-analysis for data consistency. Exaggerated responses, such as those claiming to use a false drug or extremely high levels of drug and alcohol use, were identified and dropped from the analyses. If students failed to report both their grade level and age, the data were dropped from the analyses as well.

Weights were applied to the final TSS estimates so that the aggregation of students in each campus, district, and stratum reflected their proportions in the actual district, campus, and stratum populations. The 95 percent confidence interval for estimates regarding the Texas secondary school population as a whole in 2006 was at most plus or minus 1.7 percent. Actual confidence intervals on most substances were smaller.

III. Data Sources for Needs Estimates in Texas

[1]. 2006 Population Projections for Texas, Texas State Data Center and Texas Health and Human Services Commission, Oct. 2006 version.

[2]. 2003-2006 National Survey on Drug Use and Health for Texas, OAS/SAMHSA, June 2008.
[3]. 2006 Texas School Survey of Substance Use Among Grades 7-12, DSHS, March 2008.
[4]. "Secondary School Completion and Dropouts in Texas Public Schools 2005-06," Texas Education Agency, August 2007 (Dropout rates were used to adjust the prevalence rates among in-school youths).
[5]. 2006 Behavioral Health Integrated Provider System Client Data, DSHS (It's for the percentage estimates of IVDUs among treatment clients).

IV. State Records Data for Columns 6 and 7

Column 6:
The 2006 numbers of DWI arrests and drug-related arrests were directly recorded and provided by the Uniform Crime Reporting (UCR), Texas Department of Public Safety. In UCR, crime reports are obtained from law enforcement agencies throughout the nation based on uniform classifications and procedures of reporting. Each contributing agency compiles and submits its own crime reports to the UCR program on a monthly basis. To maintain quality and uniformity in the data received, UCR field representatives provide training on detailed procedures for scoring and classifying offenses. The county-reported data was used to generate the regional data annually, which included both juvenile and adult arrests.

The DWI arrests are those offenses of driving under the influence. The drug-related arrests include those offenses of (1) sale-manufacturing of opium/cocaine, marijuana, narcotics, and other drugs, and (2) possession of opium/cocaine, marijuana, narcotics, and other drugs. The arrest data is published annually.

Column 7:
The incidence data of Hepatitis B, AIDS, and Tuberculosis is recorded and provided by DSHS annually. The Hepatitis B data was based on the 2006 reported cases of vaccine-preventable disease statistics from Immunization Branch of DSHS. The AIDS data was from the 2006 Texas HIV/STD Surveillance Report by HIV/STD Epidemiology and Surveillance Branch of DSHS and the Tuberculosis data was based on the 2006 Tuberculosis cases by public health region from Tuberculosis Elimination Division of DSHS. The case definition for these surveillance data has been used on the basis of the recommendation of the Center for Disease Control and Prevention.

The 2006 population projection numbers in Texas were used to calculate the incidence rate per 100,000 population for each index.

Form 11

State: Texas

INTENDED USE PLAN

(Include ONLY Funds to be spent by the agency administering the block grant. Estimated data are acceptable on this form)

SOURCE OF FUNDS

	(24 Month Projections)					
Activity	**A.SAPT Block Grant FY 2009 Award**	**B.Medicaid (Federal, State and Local)**	**C.Other Federal Funds (e.g., Medicare, other public welfare)**	**D.State Funds**	**E.Local Funds (excluding local Medicaid)**	**F.Other**
Substance Abuse Prevention* and Treatment	$ 88,086,948	$ 0	$ 6,500,000	$ 28,680,738	$ 0	$ 415,314
Primary Prevention	$ 33,879,595		$ 1,898,000	$ 15,305,066	$ 0	$ 0
Tuberculosis Services	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
HIV Early Intervention Services	$ 6,775,919	$ 0	$ 0	$ 2,301,776	$ 0	$ 0
Administration: (Excluding Program/Provider Lvl)	$ 6,775,919		$ 0	$ 2,434,034	$ 0	$ 0
Column Total	**$135,518,381**	**$0**	**$8,398,000**	**$48,721,614**	**$0**	**$415,314**

Form 11ab

State: Texas

Form 11a. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2009	Other Federal	State Funds	Local Funds	Other
Information Dissemination	$ 0	$ 0	$ 0	$ 0	$ 0
Education	$ 0	$ 0	$ 0	$ 0	$ 0
Alternatives	$ 0	$ 0	$ 0	$ 0	$ 0
Problem Identification & Referral	$ 0	$ 0	$ 0	$ 0	$ 0
Community Based Process	$ 0	$ 0	$ 0	$ 0	$ 0
Environmental	$ 0	$ 0	$ 0	$ 0	$ 0
Other	$ 0	$ 0	$ 0	$ 0	$ 0
Section 1926 - Tobacco	$ 129,214	$ 0	$ 74,005	$ 0	$ 0
Column Total	**$129,214**	**$0**	**$74,005**	**$0**	**$0**

Form 11b. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2009	Other Federal	State Funds	Local Funds	Other
Universal Direct	$ 11,356,543	$ 0	$ 5,125,045	$ 0	$ 0
Universal Indirect	$ 4,685,284	$ 1,898,000	$ 2,114,401	$ 0	$ 0
Selective	$ 7,940,853	$ 0	$ 3,583,593	$ 0	$ 0
Indicated	$ 9,767,700	$ 0	$ 4,408,023	$ 0	$ 0
Column Total	**$33,750,380**	**$1,898,000**	**$15,231,062**	**$0**	**$0**

Form 11c

Resource Development Planned Expenditure Checklist

State: Texas

Did your State plan to fund resource development activities with FY 2009 funds?

(•) **Yes** ( ) **No**

Activity	Treatment	Prevention	Additional Combined	Total
Planning, Coordination and Needs Assessment	$ 128	$ 47	$ 0	$ 175
Quality Assurance	$ 1,469,809	$ 542,379	$ 0	$ 2,012,188
Training (post-employment)	$ 79,533	$ 29,349	$ 0	$ 108,882
Education (pre-employment)	$ 0	$ 0	$ 0	$ 0
Program Development	$ 550,331	$ 203,079	$ 0	$ 753,410
Research and Evaluation	$ 0	$ 0	$ 0	$ 0
Information Systems	$ 308,016	$ 113,662	$ 0	$ 421,678
Column Total	**$2,407,817**	**$888,516**	**$0**	**$3,296,333**

Form 12

State: Texas

TREATMENT CAPACITY MATRIX

This form contains data covering a 24- month projection for the period during which your principal agency of the State is permitted to spend the FY 2009 block grant award.

Level of Care	A.Number of Admissions	B.Number of Persons
Detoxification (24-Hour Care)		
Hospital Inpatient (Detox)	1,101	1,030
Free-standing Residential	7,187	6,405
Rehabilitation / Residential		
Hospital Inpatient (Rehabilitation)	35	35
Short-term (up to 30 days)	12,809	11,472
Long-term (over 30 days)	4,209	3,888
Ambulatory (Outpatient)		
Outpatient	15,590	14,810
Intensive Outpatient	12,752	12,116
Detoxification	1,965	1,776
Opioid Replacement Therapy (ORT)		
Opioid Replacement Therapy	2,154	2,087

State: Texas

Purchasing Services

This item requires completing two checklists.

Methods for Purchasing

There are many methods the State can use to purchase substance abuse services. Use the following checklist to describe how your State will purchase services with the FY 2009 block grant award. Indicate the proportion of funding that is expended through the applicable procurement mechanism.

☑ Competitive grants	Percent of Expense: 90.90 %
☑ Competitive contracts	Percent of Expense: 8.90 %
☐ Non-competitive grants	Percent of Expense: %
☑ Non-competitive contracts	Percent of Expense: 0.10 %
☑ Statutory or regulatory allocation to governmental agencies serving as umbrella agencies that purchase or directly operate services	Percent of Expense: 0.10 %
☐ Other	Percent of Expense: %

(The total for the above categories should equal 100 percent.)

☐ According to county or regional priorities	Percent of Expense: %

Methods for Determining Prices

There are also alternative ways a State can decide how much it will pay for services. Use the following checklist to describe how your State pays for services. Complete any that apply. I n addressing a State's allocation of resources through various payment methods, a State may choose to report either the proportion of expenditures or proportion of clients served through these payment methods. Estimated proportions are acceptable.

☑ Line item program budget

Percent of Clients Served: %
Percent of Expenditures: 43 %

☐ Price per slot

Percent of Clients Served: %
Percent of Expenditures: %

Rate: $ Type of slot:
Rate: $ Type of slot:
Rate: $ Type of slot:

☑ Price per unit of service

Percent of Clients Served: %
Percent of Expenditures: 50 %

Unit: Rate: $

Unit:
Unit:

Rate: $
Rate: $

☑ Per capita allocation (Formula:)

Percent of Clients Served: %
Percent of Expenditures: 7 %

☐ Price per episode of care

Percent of Clients Served: %
Percent of Expenditures: %

Rate: $
Rate: $
Rate: $

Diagnostic Group:
Diagnostic Group:
Diagnostic Group:

State: Texas

Program Performance Monitoring

☑ On-site inspections

Frequency for treatment: OTHER See Footnotes

Frequency for prevention: OTHER See Footnotes

☑ Activity Reports

Frequency for treatment: MONTHLY

Frequency for prevention: OTHER Monthly, Quarterly, Annually

☑ Management Information System

☑ Patient/participant data reporting system

Frequency for treatment: MONTHLY

Frequency for prevention: MONTHLY

☑ Performance Contracts

☑ Cost reports

☑ Independent Peer Review

☑ Licensure standards - programs and facilities

Frequency for treatment: EVERY TWO YEARS

Frequency for prevention: OTHER Not Applicable

☑ Licensure standards - personnel

Frequency for treatment: EVERY TWO YEARS

Frequency for prevention: OTHER Not Applicable

Other:

☑ Specify: See Footnotes

- Foot Notes

On-site inspections
Treatment: Performed as needed, based on Risk Assessment
Prevention: Performed as needed, based on Risk Assessment (length of time since last monitoring review is a risk indicator)

Other: Internal BHIPS Reviews and Focused BHIPS Reviews
Treatment: Based on Risk Assessment
Prevention: Based on Risk Assessment

On-site inspections: A risk assessment tool was implemented in FY2007 with four clusters and 16 indicators, which places the providers in low, moderate or high risk categories. The occurrence and frequency of on-site visits is determined by the provider's rating in relevant clusters and/or indicators within the risk assessment. The risk assessment was fully implemented in FY2008.

Other: Risk assessment Protocol
Frequency: The risk assessment is run quarterly.

Other: Internal BHIPS reviews are conducted based on provider rating determined through quarterly risk assessment on all providers (which places providers in low, moderate or high-risk categori

Form T1

State: Texas

Performance Measure Data Collection
Interim Standard – Change in Employment Status
(from Admission to Discharge)

GOAL To improve the employment status of persons treated in the State's substance abuse treatment system.

MEASURE The change in *all clients receiving treatment* who reported being employed (including part-time) at discharge.

DEFINITIONS Change in *all clients receiving treatment* who reported being employed (including part-time) at admission and discharge.

Most recent year for which data are available	From: 9/1/2006	To: 8/31/2007

Employment Status – Clients employed (full-time and part-time) (prior 30 days) at admission vs. discharge	Admission Clients (T_1)	Discharge Clients (T_2)
Number of clients employed (full-time and part-time) [numerator]	6819	9103
Total number of clients with non-missing values on employment status [denominator]	20886	20886
Percent of clients employed (full-time and part-time)	32.65%	43.58%
Percent of clients employed (full-time and part-time) at discharge minus percent of clients employed at admission. (Positive percent change values indicate increased employment)	Absolute Change [$\%T_2$-$\%T_1$] 10.93% / 33.49%	

State Description of Employment Status Data Collection (Form T1)

STATE CONFORMANCE TO INTERIM STANDARD	**States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described**

The DSHS's Substance Abuse Treatment Service has developed and administers the Behavioral Health Integrated Provider System (BHIPS). It is a web-based online clinical record used by DSHS to collect information from the DSHS-funded substance abuse treatment services. Providers access the BHIPS system through a web server. The information provided to DSHS allows the state agency to measure capacity, effectiveness, and need. DSHS receives information from each client whenever an action takes place (e.g., admission, transfer, discharge and follow-up) as well as every time a client receives a unit of service (individual session, group session). The system has been in use since FY2000 with very little change to the instruments that provide the information gathered for this report. The data reported in this application is for clients discharged in FY 2007. The BHIPS system includes the Admission Report and the Discharge Report. These protocols include items to collect information regarding employment status at a admission and discharge. The information on employment status is based on self-reports by clients who are seeking substance abuse treatment from a publicly-funded treatment provider. DSHS uses the following categories for employment status: "employed full-time," "Employed part-time," "Not employed, not seeking employment," "Not in the labor force," and "Unemployed, no seeking

	employment." For this report, we cross-tabulated the information of employment at admission with employment at discharge. Only clients employed and not employed seeking employment at admission and discharge where considered for the analyses. DSHS has created a system to assign each client a unique identification number. It is based on a matching procedure of the following variables: • Last 4 digits of the Social Security Number • Client's ethnicity • Client's date of birth • Gender • First five letters of the city where the client was born • The client's mother's first name initials. All of these variables are collected at admission for all the clients.

DATA SOURCE	**What is the source of data for table T1? (Select all that apply)** ☑ Client Self Report Client self-report confirmed by another source: ☐ Collateral source ☐ Administrative data source ☐ Other: Specify

EPISODE OF CARE	**How is the admission/discharge basis defined for table T1? (Select one)** ◉ Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days ○ Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit ○ Other, Specify:

DISCHARGE DATA COLLECTION	**How was discharge data collected for table T1? (Select all that apply)** ☐ Not applicable, data reported on form is collected at time period other than discharge Specify: ○ In-Treatment data ____ days post admission ○ Follow-up data ____ months post admission ○ Other, Specify: ☑ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment ☐ Discharge data is collected for a sample of all clients who were admitted to treatment ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment ☐ Discharge records are not collected for approximately ____ % of clients who were admitted for treatment

RECORD LINKING	**Was the admission and discharge data linked for table T1? (Select all that apply)** ☑ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID: ○ Master Client Index or Master Patient Index, centrally assigned

	○ Social Security Number (SSN) ◉ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) ○ Some other Statewide unique ID ○ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching
IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.
DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T2

State: Texas

Performance Measure Data Collection
Interim Standard – Number of Clients and Change in Homelessness (Living Status)

GOAL To improve living conditions of persons treated in the State's substance abuse treatment system.

MEASURE The change in *all clients receiving treatment* who reported being homeless at discharge.

DEFINITIONS Change in *all clients receiving treatment* who reported being homeless at discharge equals the clients reporting being homeless at admission subtracted from the clients reporting being homeless at discharge.

Most recent year for which data are available	From: 9/1/2006	To: 8/31/2007

Homelessness – Clients homeless (prior 30 days) at admission vs. discharge	Admission Clients (T_1)	Discharge Clients (T_2)
Number of clients homeless [numerator]	2105	764
Total number of clients with non-missing values on living arrangements [denominator]	29101	29101
Percent of clients homeless	7.23%	2.63%
Percent of clients homeless at discharge minus percent of clients homeless at admission. (Negative percent change values indicate reduced homelessness)	Absolute Change [$\%T_2$-$\%T_1$] -4.60% / -63.71%	

State Description of Homelessness (Living Status) Data Collection (Form T2)

STATE CONFORMANCE TO INTERIM STANDARD	**States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described** Texas DSHS system conforms to the living status as defined in the Interim Standard for Data Collection. The definitions of living status' categories are the same as TEDS. We match admission to discharge records through a unique statewide client ID. See T1 information regarding how the unique client identification number was constituted.

DATA SOURCE	**What is the source of data for table T2? (Select all that apply)** ☑ Client Self Report Client self-report confirmed by another source: ☐ Collateral source

	☐ Administrative data source ☐ Other: Specify
EPISODE OF CARE	**How is the admission/discharge basis defined for table T2? (Select one)** ◉ Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days ○ Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit ○ Other, Specify:
DISCHARGE DATA COLLECTION	**How was discharge data collected for table T2? (Select all that apply)** ☐ Not applicable, data reported on form is collected at time period other than discharge Specify: ○ In-Treatment data ____ days post admission ○ Follow-up data ____ months post admission ○ Other, Specify: ____ ☑ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment ☐ Discharge data is collected for a sample of all clients who were admitted to treatment ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment ☐ Discharge records are not collected for approximately ____ % of clients who were admitted for treatment
RECORD LINKING	**Was the admission and discharge data linked for table T2? (Select all that apply)** ☑ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID: ○ Master Client Index or Master Patient Index, centrally assigned ○ Social Security Number (SSN) ◉ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) ○ Some other Statewide unique ID ○ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching
IF DATA IS	**If data is not reported, why is State unable to report? (Select all that apply)**

UNAVAILABLE	☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing living status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T3

State: Texas

Performance Measure Data Collection
Interim Standard – Change of Persons Arrested

GOAL To reduce the criminal justice involvement of persons treated in the State's substance abuse treatment system.

MEASURE The change in persons arrested in the last 30 days at discharge for *all clients receiving treatment*.

DEFINITIONS Change in persons arrested in the last 30 days at discharge for *all clients receiving treatment* equals clients who were arrested in the 30 days prior to admission subtracted from clients who were arrested in the last 30 days at discharge. An arrest is any arrest.

Most recent year for which data are available	From: 9/1/2006	To: 8/31/2007

Arrests – Clients arrested (any charge) (prior 30 days) at admission vs. discharge	Admission Clients (T_1)	Discharge Clients (T_2)
Number of Clients arrested [numerator]	2751	1338
Total number of clients with non-missing values on arrests [denominator]	27886	27886
Percent of clients arrested	9.87%	4.80%
Percent of clients arrested at discharge minus percent of clients arrested at admission. (Negative percent change values indicate reduced arrests)	Absolute Change [$\%T_2$-$\%T_1$] -5.07% / -51.36%	

State Description of Number of Arrests Data Collection (Form T3)

STATE CONFORMANCE TO INTERIM STANDARD	**States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described** Texas DSHS uses matched clients data based on a unique number identifier and is able to match a client's admission and discharge records. The Admission and Discharge Forms include questions about the number of arrests during the prior 30 days to admission and 30 days prior to discharge or since admission.

DATA SOURCE	**What is the source of data for table T3? (Select all that apply)** ☑ Client Self Report Client self-report confirmed by another source: ☐ Collateral source

	☐ Administrative data source ☐ Other: Specify
EPISODE OF CARE	**How is the admission/discharge basis defined for table T3? (Select one)** ◉ Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days ○ Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit ○ Other, Specify:
DISCHARGE DATA COLLECTION	**How was discharge data collected for table T3? (Select all that apply)** ☐ Not applicable, data reported on form is collected at time period other than discharge Specify: ○ In-Treatment data ____ days post admission ○ Follow-up data ____ months post admission ○ Other, Specify: ____ ☑ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment ☐ Discharge data is collected for a sample of all clients who were admitted to treatment ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment ☐ Discharge records are not collected for approximately ____ % of clients who were admitted for treatment
RECORD LINKING	**Was the admission and discharge data linked for table T3? (Select all that apply)** ☑ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID: ○ Master Client Index or Master Patient Index, centrally assigned ○ Social Security Number (SSN) ◉ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) ○ Some other Statewide unique ID ○ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching
IF DATA IS	**If data is not reported, why is State unable to report? (Select all that apply)**

UNAVAILABLE	☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing arrest data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T4

State: Texas

Performance Measure Data Collection
Interim Standard – Percentage Point Change in Abstinence - Alcohol Use

GOAL	To reduce substance abuse to protect the health, safety, and quality of life for all.
MEASURE	The change in *all clients receiving treatment* who reported abstinence at discharge.
DEFINITIONS	Change in *all clients receiving treatment* who reported abstinence at discharge equals clients reporting abstinence at admission subtracted from clients reporting abstinence at discharge.

Most recent year for which data are available	From: 9/1/2006	To: 8/31/2007

Alcohol Abstinence – Clients with no alcohol use (all clients regardless of primary problem) (use Alcohol Use in last 30 days field) at admission vs. discharge.	Admission Clients (T_1)	Discharge Clients (T_2)
Number of clients abstinent from alcohol [numerator]	6104	12833
Total number of clients with non-missing values on "used any alcohol" variable [denominator]	15708	15708
Percent of clients abstinent from alcohol	38.86%	81.70%
Percent of clients abstinent from alcohol at discharge minus percent of clients abstinent from alcohol at admission. (Positive percent change values indicate increased alcohol abstinence)	Absolute Change [$\%T_2$-$\%T_1$] 42.84% / 110.24%	
(1) If State does not have a "used any alcohol" variable, calculate instead using frequency of use variables for all primary, secondary, or tertiary problem codes in which the coded problem is Alcohol (e.g. ,TEDS Code 02)		

State Description of Alcohol Use Data Collection (Form T4)

STATE CONFORMANCE TO INTERIM STANDARD	**States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described** Texas DSHS tracks client-level data by matching admission to discharge records through a unique statewide client ID. The Admission and Discharge Forms are designed to gather information on primary, secondary and tertiary substances whether it be alcohol or any other drugs. We also collect information on the number of days used during the 30 days prior to admission and the number of days substance was used during the 30 days prior to discharge or since admission, if the client stayed in service for less than 30 days for the primary, secondary and tertiary substances. We used the definition of abstinence from alcohol as defined in the Interim Standard for Data Collection.

DATA SOURCE	

What is the source of data for table T4? (Select all that apply)

☑ Client Self Report

Client self-report confirmed by another source:

- ☐ Collateral source
- ☐ Administrative data source

☐ Other: Specify

EPISODE OF CARE	**How is the admission/discharge basis defined for table T4? (Select one)**

◉ Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days

○ Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit

○ Other, Specify:

DISCHARGE DATA COLLECTION	**How was discharge data collected for table T4? (Select all that apply)**

☐ Not applicable, data reported on form is collected at time period other than discharge
Specify:

- ○ In-Treatment data ____ days post admission
- ○ Follow-up data ____ months post admission
- ○ Other, Specify:

☑ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment

☐ Discharge data is collected for a sample of all clients who were admitted to treatment

☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment

☐ Discharge records are not collected for approximately ____ % of clients who were admitted for treatment

RECORD LINKING	**Was the admission and discharge data linked for table T4? (Select all that apply)**

☑ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)
Select type of UCID:

- ○ Master Client Index or Master Patient Index, centrally assigned
- ○ Social Security Number (SSN)
- ◉ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.)
- ○ Some other Statewide unique ID
- ○ Provider-entity-specific unique ID

☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data

	sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching

IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing alcohol abstinance data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T5

State: Texas

Performance Measure Data Collection
Interim Standard – Percentage Point Change in Abstinence - Other Drug Use

GOAL	To reduce substance abuse to protect the health, safety, and quality of life for all.
MEASURE	The change in *all clients receiving treatment* who reported abstinence at discharge.
DEFINITIONS	Change in *all clients receiving treatment* who reported abstinence at discharge equals clients reporting abstinence at admission subtracted from clients reporting abstinence at discharge.

Most recent year for which data are available	From: 9/1/2006	To: 8/31/2007

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) (use Any Drug Use in last 30 days field) at admission vs. discharge.	Admission Clients (T_1)	Discharge Clients (T_2)
Number of Clients abstinent from illegal drugs [numerator]	16908	28304
Total number of clients with non-missing values on "used any drug" variable [denominator]	34819	34819
Percent of clients abstinent from drugs	48.56%	81.29%
Percent of clients abstinent from drugs at discharge minus percent of clients abstinent from drugs at admission. (Positive percent change values indicate increased drug abstinence)	Absolute Change [$\%T_2$-$\%T_1$] 32.73% / 67.40%	
(2) If State does not have a "used any drug" variable, calculate instead using frequency of use variables for all primary, secondary, or tertiary problem codes in which the coded problem is Drugs (e.g., TEDS Codes 03-20)		

State Description of Other Drug Use Data Collection (Form T5)

STATE CONFORMANCE TO INTERIM STANDARD	**States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described** Texas DSHS tracks client-level data by matching admission to discharge records through a unique statewide client ID. The Admission and Discharge Forms are designed to gather information on primary, secondary and tertiary whether it is alcohol or any other drugs. We also collect information on the number of days used during the 30 days prior to admission and the number of days substance was used during the 30 days prior to discharge or since admission, if the client stayed in service for less than 30 days for the primary, secondary and tertiary substances.

DATA SOURCE	**What is the source of data for table T5? (Select all that apply)** ☑ Client Self Report

Client self-report confirmed by another source:
- ☐ Collateral source
- ☐ Administrative data source

☐ Other: Specify

EPISODE OF CARE	**How is the admission/discharge basis defined for table T5? (Select one)**

◉ Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days

○ Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit

○ Other, Specify:

DISCHARGE DATA COLLECTION	**How was discharge data collected for table T5? (Select all that apply)**

☐ Not applicable, data reported on form is collected at time period other than discharge
Specify:
- ○ In-Treatment data ____ days post admission
- ○ Follow-up data ____ months post admission
- ○ Other, Specify: ____

☑ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment

☐ Discharge data is collected for a sample of all clients who were admitted to treatment

☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment

☐ Discharge records are not collected for approximately ____ % of clients who were admitted for treatment

RECORD LINKING	**Was the admission and discharge data linked for table T5? (Select all that apply)**

☑ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)
Select type of UCID:
- ○ Master Client Index or Master Patient Index, centrally assigned
- ○ Social Security Number (SSN)
- ◉ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.)
- ○ Some other Statewide unique ID
- ○ Provider-entity-specific unique ID

☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data

☐ No, admission and discharge records were matched using probabilistic record matching

IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing drug abstinance data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T6

State: Texas

Performance Measure Data Collection
Interim Standard – Percentage Point Change in Social Support of Recovery

GOAL	To improve clients' participation in social support of recovery activities to reduce substance abuse to protect the health, safety, and quality of life for all.
MEASURE	The change in *all clients receiving treatment* who reported participation in one or more social and or recovery support activity at discharge.
DEFINITIONS	Change in *all clients receiving treatment* who reported participation in one or more social and recovery support activities at discharge equals clients reporting participation at admission subtracted from clients reporting participation at discharge.

Most recent year for which data are available	From: 9/1/2006	To: 8/31/2007

Social Support of Recovery – Clients participating in self-help groups, support groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	Admission Clients (T_1)	Discharge Clients (T_2)
Number of clients with one or more such activities (AA NA meetings attended, etc.) [numerator]	7808	19202
Total number of Admission and Discharge clients with non-missing values on social support activities [denominator]	26300	26300
Percent of clients participating in social support activities	29.69%	73.01%
Percent of clients participating in social support of recovery activities in prior 30 days at discharge minus percent of clients participating in social support of recovery activities in prior 30 days at admission. (Positive percent change values indicate increased participation in social support of recovery activities.)	Absolute Change [$\%T_2$-$\%T_1$] 43.32% / 145.93%	

State Description of Social Support of Recovery Data Collection (Form T6)

STATE CONFORMANCE TO INTERIM STANDARD	**States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described** Texas DSHS tracks client-level data by matching admission to discharge records through a unique statewide client ID. The Admission Report includes items to gather information regarding the number of days the client attended a chemical dependency support group during the 30 days prior to admission. This could include Alcoholic Anonymous, Narcotic Anonymous, or any other chemical dependency support group. The Discharge Record included a variable to measure the number of days client attended an off-campus community chemical dependency support group while in treatment. This could include AA, NA, CA or any other chemical dependency support groups.

DATA SOURCE	**What is the source of data for table T6? (Select all that apply)** ☑ Client Self Report Client self-report confirmed by another source: ☐ Collateral source ☐ Administrative data source ☐ Other: Specify
EPISODE OF CARE	**How is the admission/discharge basis defined for table T6? (Select one)** ◉ Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days ○ Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit ○ Other, Specify:
DISCHARGE DATA COLLECTION	**How was discharge data collected for table T6? (Select all that apply)** ☐ Not applicable, data reported on form is collected at time period other than discharge Specify: ○ In-Treatment data ____ days post admission ○ Follow-up data ____ months post admission ○ Other, Specify: ____ ☑ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment ☐ Discharge data is collected for a sample of all clients who were admitted to treatment ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment ☐ Discharge records are not collected for approximately ____ % of clients who were admitted for treatment
RECORD LINKING	**Was the admission and discharge data linked for table T6? (Select all that apply)** ☑ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID: ○ Master Client Index or Master Patient Index, centrally assigned ○ Social Security Number (SSN) ◉ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) ○ Some other Statewide unique ID ○ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data

	sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching

IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing social support of recovery data data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T7

State: Texas

Length of Stay (in Days) of All Discharges

Most recent year for which data are available	From: 9/1/2006 To: 8/31/2007

Length of Stay			
Level of Care	**Average**	**Median**	**Standard Deviation**
Detoxification (24-Hour Care)			
1. Hospital Inpatient	6.34	6	1.74
2. Free-standing Residential	5.99	6	2.46
Rehabilitation / Residential			
3. Hospital Inpatient	39	28	30.50
4. Short-term (up to 30 days)	32.07	28	35.10
5. Long-term (over 30 days)	35.10	29	24.10
Ambulatory (Outpatient)			
6. Outpatient	95.64	82	75.90
7. Intensive Outpatient	76.15	65	53.90
8. Detoxification	11.04	7	10.85
Opioid Replacement Therapy (ORT)			
9. Opioid Replacement therapy	365.70	240	433.49

Texas
INSERT OVERALL NARRATIVE:

INSERT OVERALL NARRATIVE:

The State should address as many of these questions as possible and may provide other relevant information if so desired. Responses to questions that are already provided in other sections of the application (e.g., planning, needs assessment) should be referenced whenever possible.

State Performance Management and Leadership

Describe the Single State Agency's capacity and capability to make data driven decisions based on performance measures. Describe any potential barriers and necessary changes that would enhance the SSA's leadership role in this capacity.
Describe the types of regular and ad hoc reports generated by the State and identify to whom they are distributed and how.
If the State sets benchmarks, performance targets or quantified objectives, what methods are used by the State in setting these values?
What actions does the State take as a result of analyzing performance management data?
Has the State developed evidence-based practices (EBPs) or programs and, if so, does the State require that providers use these EBPs?

Provider Involvement

What actions does the State expect the provider or intermediary to take as a result of analyzing performance management data?
If the SSA has a regular training program for State and provider staff that collect and report client information, describe the training program, its participants and frequency. Do workforce development plans address NOMs implementation and performance-based management practices? Does the State require providers to supply information about the intensity or number of services received?

Treatment Performance Measures (Overall Narrative)

Describe the Single State Authority capacity and capability to make data driven decisions based on performance measures. Describe any potential barriers and necessary changes that would enhance the SSA's leadership role in this capacity.

The practice of establishing and using performance measures as the basis for contract management is well established in the DSHS-MHSA Division's system. The Texas Department of State Health Services (DSHS) has implemented performance-based management of funded substance abuse treatment providers (contract management based on performance measures) since 1995. The performance measures targets for providers are established in the contracts. The contracts stipulate the services to be provided, the estimated number of individuals to be served, and a proposed budget. Each contract includes expected performance measures.

All funded providers are required to utilize the Behavioral Health Integrated Provider System (BHIPS), a system whereby providers submit via internet completed forms for each client admitted. The client's records include the Admission and Discharge Forms where TEDS information is collected, billings for services rendered, clinical records, and other information. Performance measures are measured using clients' records and comparing status at admission and discharge.

To ensure continuity and a culture that incorporates this practice and to enhance the capacity of the leadership regarding performance measure management, it is necessary to emphasize the training of new hires as changes in both leadership and staff positions occur.

Describe the types of regular and ad hoc reports generated by the State and identify to whom they are distributed and how.

DSHS's Division of Mental Health and Substance Abuse Services develop quarterly reports for the Legislative Budget Board (LBB) on the Division's performance measures. The reports include financial and performance measures and justification of below-target performance, as required of all reporting government units. DSHS reviews and updates performance targets once a year.

DSHS's Division of Mental Health and Substance Abuse Services develops reports on performance measures and provides the reports to funded providers. The frequency of the reports depends on the program type. Substance abuse receives reports monthly, except the methadone performance measures that are reported once a year after completion of the Methadone Annual Survey and Customer Satisfaction Survey. Funded providers may request ad-hoc reports at any time. In addition, the BHIPS system makes summary reports available and accessible to service providers.

The DSHS-MHSA Decision Support Unit has developed a risk assessment report format that allows us to identify providers at risk. Risk status is determined by an analysis of selected variables, including financial, programmatic, and performance measures. This report is

submitted quarterly to the Quality Management Unit, the unit in charge of monitoring contract compliance. As a consequence of the risk report, several actions may result including calls to the providers requesting explanations and corrective actions, suspension of payments until further information is provided to the state, or in its most extreme cases, cancellation of contracts.

Monitoring of providers not at risk is done by conducting visits to interview the providers' staff, audit records, and contact clients to verify information. Program officers request performance measures be provided to the Decision Support Unit before visiting the providers for verification and monitoring. After the monitoring visits, Quality Management prepares a Final Report where the findings of the visit are discussed.

Performance measures data is analyzed at two levels: the provider level to identify under-performers, and the statewide level to identify trends and compare overall system performance with prior years to establish targets.

If the State sets benchmarks, performance targets or quantified objectives, what methods are used by the State in setting these values?

Performance targets are established by analyzing and comparing past performance data from prior years. The process for establishing targets also considers changes in population, policy decisions and/or other factors.

The selection of performance measure variables is based on reviews of the scientific literature on substance abuse treatment and substance abuse prevention.

What actions does the State take as a result of analyzing performance management data?

If a provider is found to have performed under expectations (e.g., not meeting targets), DSHS follows a review procedure that consists of:

- informing the provider's executive management of its non-compliance status and requesting relevant and appropriate changes in the operational procedures;
- conducting site visits to inspect records and review programmatic issues; and
- providing technical assistance and training.

Continuous under-performance of a provider classified "at-risk" and non-compliant with rules and regulations may be cause for termination of state funding.

Has the State developed evidence-based practices (EBPs) or programs and, if so, does the State require that providers use these EBPs?

In 2004, DSHS began requiring all providers of prevention services to implement evidence-based curricula. To be funded, providers were asked to identify the population to be served based on the Institute of Medicine's (IOM) classification and to begin implementing model curricula included in SAMHSA's NREPP list.

For substance abuse treatment, DSHS promotes and encourages funded providers to implement evidence-based interventions such as motivational interviewing, clients' screening and assessment with instruments that have scientifically established psychometric properties, and other best practices such as placement in the most appropriate level of care according to severity of addiction.

Provider Involvement

What actions does the State expect the provider or intermediary to take as a result of analyzing performance management data?

DSHS expects under-performing providers to review their program implementation procedures and other factors such as changes in the population served, personnel, documentation, and data reporting to identify feasible changes. The state will facilitate training and provide technical assistance, if necessary.

If the SSA has a regular training program for State and provider staff that collect and report client information, describe the training, its participants and frequency.

DSHS requires that funded providers enter demographic, service encounter and clinical information on individuals receiving substance abuse services via clinical and administrative screens in BHIPS. DSHS schedules and offers trainings for contracted treatment staff on how to use BHIPS in its entirety approximately twice a month. Substance abuse prevention and intervention providers submit performance measures electronically using another function within the BHIPS system. Trainings on the use of this BHIPS functionality are scheduled on an "as needed" basis.

Do workforce development plans address NOMs implementation and performance-based management practices?

DSHS contracts include performance measures stipulated in the contracts with substance abuse treatment and prevention providers. DSHS reports to providers include performance measures. DSHS's Technical Assistance and Training Unit provides training for providers regarding performance measures.

Does the state require providers to supply information abut the intensity or number of services received?

Substance abuse treatment providers enter service encounter data into BHIPS to generate a bill for reimbursement based on a fee-for-services method. Therefore, the number and amount (intensity) of substance abuse treatment services per individual data is readily available to DSHS.

Prevention service providers are paid on a cost-reimbursement basis. However, for primary prevention providers implementing universal, selective, or indicated services to groups of individuals, the state requires them to report the number of cycles and sessions implemented by

curriculum. This is one of the procedures used by DSHS for monitoring the fidelity of the model programs implementation.

Texas
Treatment Corrective Action Plan (submit upon request)

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.

2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.

3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

Form P1

State: Texas

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: 30-Day Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. 30-day Alcohol Use	**Source Survey Item:** NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from **[DATEFILL]** through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used alcohol during the past 30 days.	Ages 12–17 - FFY 2006	27	
		Ages 18+ - FFY 2006	53.90	
2. 30-day Cigarette Use	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you smoke part or all of a cigarette?" [Response option: Write in a number between 0 and 30.]	Ages 12–17 - FFY 2006	8.90	
		Ages 18+ - FFY 2006	28	
3. 30-day Use of Other Tobacco Product	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you use [other tobacco products] † ?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used a tobacco product other than cigarettes during the past 30 days,	Ages 12–17 - FFY 2006	5.40	
		Ages 18+ - FFY 2006	9.60	
4. 30-day Use of Marijuana	**Source Survey Item:** NSDUH Questionnaire: "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used marijuana or hashish during the past 30 days.	Ages 12–17 - FFY 2006	5.50	
		Ages 18+ - FFY 2006	4.10	
5. 30-day Use of Illegal Drugs Other Than Marijuana	**Source Survey Item:** NSDUH Questionnaire: "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use [any other illegal drug] ‡ ?" **Outcome Reported:** Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, stimulants, hallucinogens, inhalants, prescription drugs used without doctors' orders).	Ages 12–17 - FFY 2006	4.50	
		Ages 18+ - FFY 2006	3.80	

((s)) Suppressed due to insufficient or non-comparable data

† NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.
‡ NSDUH asks separate questions for each illegal drug. The number provided combines responses to all questions about illegal drugs other than marijuana or hashish.

Form P2

State: Texas

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Perception of Risk/Harm of Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Perception of Risk From Cigarette	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - FFY 2006	92.80	
		Ages 18+ - FFY 2006	93.30	
1. Perception of Risk From Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - FFY 2006	79	
		Ages 18+ - FFY 2006	80.40	
3. Perception of Risk From Marijuana	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - FFY 2006	83.80	
		Ages 18+ - FFY 2006	80.40	

((s)) Suppressed due to insufficient or non-comparable data

Form P3

State: Texas

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Age of First Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Age at First Use of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink." [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of alcohol.	Ages 12–17 - FFY 2006	13	
		Ages 18+ - FFY 2006	17.20	
2. Age at First Use of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of cigarettes.	Ages 12–17 - FFY 2006	12.70	
		Ages 18+ - FFY 2006	16.20	
3. Age at First Use of Tobacco Products Other Than Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product] † ?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of tobacco products other than cigarettes.	Ages 12–17 - FFY 2006	13.10	
		Ages 18+ - FFY 2006	19.40	
4. Age at First Use of Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of marijuana or hashish.	Ages 12–17 - FFY 2006	13.50	
		Ages 18+ - FFY 2006	18.20	
5. Age at First Use of Illegal Drugs Other Than Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [other illegal drugs] ‡ ?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of other illegal drugs.	Ages 12–17 - FFY 2006	12.70	
		Ages 18+ - FFY 2006	20.80	

((s)) Suppressed due to insufficient or non-comparable data

† The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.
‡ The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.

Form P4

State: Texas

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Perception of Disapproval/Attitudes

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2006	88.20	
2. Perception of Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent reporting that their friends would somewhat or strongly disapprove.	Ages 12–17 - FFY 2006	86.50	
3. Disapproval of Using Marijuana Experimentally	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age trying marijuana or hashish once or twice?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2006	83.30	
4. Disapproval of Using Marijuana Regularly	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age using marijuana once a month or more?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2006	84	
5. Disapproval of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2006	84.70	

((s)) Suppressed due to insufficient or non-comparable data

Form P5

State: Texas

NOMs Domain: Employment/Education
Measure: Perception of Workplace Policy

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Perception of Workplace Policy	**Source Survey Item:** NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?" [Response options: More likely, less likely, would make no difference] **Outcome Reported:** Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.	Ages 15–17 - FFY 2006	31.60	
		Ages 18+ - FFY 2006	47.30	

((s)) Suppressed due to insufficient or non-comparable data

Form P7

State: Texas

NOMs Domain: Employment/Education
Measure: Average Daily School Attendance Rate

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Average Daily School Attendance Rate	**Source:**National Center for Education Statistics, Common Core of Data: The National Public Education Finance Survey available for download at http://nces.ed.gov/ccd/stfis.asp **Measure calculation:** Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.	FFY 2006	92.70	

((s)) Suppressed due to insufficient or non-comparable data

Form P8

State: Texas

NOMs Domain: Crime and Criminal Justice
Measure: Alcohol-Related Traffic Fatalities

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol-Related Traffic Fatalities	**Source:** National Highway Traffic Safety Administration Fatality Analysis Reporting System **Measure calculation:** The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.	FFY 2006	48.30	

((s)) Suppressed due to insufficient or non-comparable data

Form P9

State: Texas

NOMs Domain: Crime and Criminal Justice
Measure: Alcohol- and Drug-Related Arrests

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol- and Drug-Related Arrests	**Source:** Federal Bureau of Investigation Uniform Crime Reports **Measure calculation:** The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.	FFY 2006	110.50	

((s)) Suppressed due to insufficient or non-comparable data

Form P10

State: Texas

NOMs Domain: Social Connectedness
Measure: Family Communications Around Drug and Alcohol Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Family Communications Around Drug and Alcohol Use (Parents of children aged 12–17)	**Source Survey Item:** NSDUH Questionnaire: "Now think about the past 12 months, that is, from **[DATEFILL]** through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you." [Response options: Yes, No] **Outcome Reported:** Percent reporting having talked with a parent.	Ages 12–17 - FFY 2006	58.10	
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12–17)	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?" † [Response options: 0 times, 1 to 2 times, a few times, many times] **Outcome Reported:** Percent of parents reporting that they have talked to their child.	Ages 18+ - FFY 2006	91.60	

((s)) Suppressed due to insufficient or non-comparable data

† NSDUH does not ask this question of all sampled parents. It is a validation question posed to parents of 12- to 17-year-old survey respondents. Therefore, the responses are not representative of the population of parents in a State. The sample sizes are often too small for valid reporting.

Form P11

State: Texas

NOMs Domain: Retention

Measure: Percentage of Youth Seeing, Reading, Watching, or Listening to a Prevention Message

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Exposure to Prevention Messages	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use] † ?" **Outcome Reported:** Percent reporting having been exposed to prevention message.	Ages 12–17 - FFY 2006	88.60	

((s)) Suppressed due to insufficient or non-comparable data

† This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context.

Form P12A

State: Texas

Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Question 1: Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

The data collection system used was the Behavioral Health Integrated provider System (BHIPS). This is the system used by the Texas Department of State Health Services to collect data from funded providers regarding client characteristics, performance measures, services provided, and financial data. Funded providers are contractually obligated to report data to DSHS on a monthly and/or quarterly measure depending on the variable of interest.

Question 2: Describe how your State's data collection and reporting processes record a participant's race, specifically for participants who are more than one race. Indicate whether the State added those participants to the number for each applicable racial category or whether the State added all those participants to the More Than One Race subcategory.

Texas DSHS adapted the racial categories selected by NOMS in FY 2006. DSHS includes a "More Than One Race" subcategory. A major change in our state was separating Hispanic/Latino from the racial category. Texas collects demographic information for youth and adults participating in the direct individual-based programs (YPU, YPS, and YPI). These programs and strategies are provided to individuals or group of individuals who do not require treatment for substance abuse who receive the services over a period of time in a planned sequence of activities that are intended to inform educate, develop skills, alter risk behaviors, or deliver services. In these programs, each individual is considered a program participants and individual information is recorded for gender, age, race and ethnicity. Data reported is based on actual counts -- not on estiamtes of people served. for FY 2007, we have demographic information for 215,215 youth and adults. DSHS asks providers to report total numbers served by measure and strategy. The numbers reported in this report aim at presenting an unduplicated count of youth and adults served by program type.

Category	Description	Total Served
A. Age	1. 0-4	1377
	2. 5-11	98192
	3. 12-14	69887
	4. 15-17	36329
	5. 18-20	991
	6. 21-24	1245
	7.25-44	5645
	8. 45-64	1443

	9. 65 And Over	106
	10. Age Not Known	0
B. Gender	Male	109168
	Female	106047
C. Race	White	149385
	Black or African American	38213
	Native Hawaiian/Other Pacific Islander	272
	Asian	2141
	American indian/Alaska Native	2696
	Race Not Known or Other (not OMB required)	13425
D. Ethnicity	Hispanic or Latino	100271
	Not Hispanic or Latino	114944

- Foot Notes

Total Served indicated for Ages 21-24 are actually for Ages 21-25.
Total Served indicated for Ages 25-44 are actually for Ages 26-44.

As indicated in the response to Question 2, DSHS has a subcategory of "More Than One Race" as follows: C. Race - More Than One Race (not OMB required) = 9,070.

Form P12B

State: Texas

Population-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Description	Total Served
A. Age	1. 0-4	555898
	2. 5-11	526350
	3. 12-14	519283
	4. 15-17	535328
	5. 18-20	0
	6. 21-24	485667
	7.25-44	1939842
	8. 45-64	1303500
	9. 65 And Over	725057
	10. Age Not Known	0
B. Gender	Male	3241321
	Female	3349603
	Gender Unknown	0
C. Race	White	4646315
	Black or African American	745687
	Native Hawaiian/Other Pacific Islander	4940
	Asian	126616
	American indian/Alaska Native	40482

	More Than One Race (not OMB required)	134014
	Race Not Known or Other (not OMB required)	867821
D. Ethnicity	Hispanic or Latino	2548599
	Not Hispanic or Latino	4042325

- Foot Notes

Total Served indicated for Ages 0-4 is actually for Ages 0-5.
Total Served indicated for Ages 5-11 is actually for Ages 5-9.
Total Served indicated for Ages 12-14 is actually for Ages 10-14.
Total Served indicated for Ages 15-17 is actually for Ages 15-19.
Total Served indicated for Ages 21-24 is actually for Ages 20-24.

Sources of Information:
Table 2: Number and Percent of Persons by Age Group for the Sate of Texas and Counties in Texas, 1990 and 2000 Texas State Data Center and Office of the Demographer.
http://txsdc.utsa.edu/data/census/2000/dpl/county/cntab_2.txt

2006 American Community Survey, Data Profile Highlights, U.S. Census Bureau, 2006 American Community Surveys

Population Estiamtes: 2007 Population Estimates

Form P13

State: Texas

Number of Persons Served by Type of Intervention

Intervention Type	Number of Persons Served by Individual- or Population-Based Program or Strategy	
	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct	146671	N/A
2. Universal Indirect	N/A	6629288
3. Selective	36980	N/A
4. Indicated	31564	N/A
5. Total	215215	6629288

Form P14

State: Texas

Evidence-Based Programs and Strategies by Type of Intervention

NOMs Domain: Retention
NOMs Domain: Evidence-Based Programs and Strategies
Measure: Number of Evidence-Based Programs and Strategies

Definition of Evidence-Based Programs and Strategies: The guidance document for the Strategic Prevention Framework State Incentive Grant, Identifying and Selecting Evidence-based Interventions, provides the following definition for evidence-based programs:

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
  - Guideline 1: The intervention is based on a solid theory or theoretical perspective that has validated research, and
  - Guideline 2: The intervention is supported by a documented body of knowledge—a converging of empirical evidence of effectiveness—generated from similar or related interventions that indicate effectiveness, and
  - Guideline 3: The intervention is judged by informed experts to be effective (i.e., reflects and documents consensus among informed experts based on their knowledge that combines theory, research, and practice experience). "Informed experts" may include key community prevention leaders, and elders or other respected leaders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition.
DSHS funds prevention programs that implement prevention curriculum considered to be evidence based. DSHS criterion to define a program as evidence-based is by knowing what curricula the provider is implementing. DSHS verifies whether the curriculum has been defined as a model program by the National Registry of Evidence-based Programs and Practices. If the curriculum selected by a provider is not in the list, then DSHS will research the professional literature (professional journals with peer reviews) for information regarding published program evaluation results. DSHS asked providers funded to implement community coalitions to base their work utilizing the Communities mobilizing for Change on Alcohol, an NREPP-approved program.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?
For prevention programs, each provider presents a statement of work indicating the population to be served (universal, selective, indicated), the demographic characteristics of the population by age group, and the curriculum to be implemented. DSHS verifies whether the proposed curriculum is considered evidence-based and whether it is appropriate for the participants' age and population type. The sources of information are the DSHS Program Records (e.g. Statement of Work). This document also identifies where the prevention program will be implemented (name of the schools, community sites, etc.) Form P14 shows the number of DSHS-funded community coalitions under the Universal Indirect category. These are providers funded to assess communities' needs, and implement strategies to assess needs in a community-related underage drinking or abuse of illicit substances; develop and implement an action plan; build community support; maintain an organization and institutionalize changes; and evaluate changes.

Number of Evidence-Based Programs and Strategies by Type of Intervention

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selected	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	56	23	79	56	54	189
2. Total number of Programs and Strategies Funded	56	22	78	56	54	188

3. Percent of Evidence-Based Programs and Strategies	100.00%	104.55%	101.28%	100.00%	100.00%	100.53%

- Foot Notes

Indicated programs include RBI and YPI programs.

Form P15

State: Texas

Services Provided Within Cost Bands

Type of Intervention	A. Number of Programs and Strategies	B. Number of Programs and Strategies Falling Within Cost Bands	C. Percent of Programs and Strategies Falling Within Cost Bands
1. Universal Direct Programs and Strategies	56	33	59 %
2. Universal Indirect Programs and Strategies	13	12	92 %
3. Subtotal Universal Programs	69	45	65.22%
4. Selective Programs and Strategies	56	32	57 %
5. Indicated Programs and Strategies	54	17	32 %
6. Total All Programs	179	94	52.51%

- Foot Notes

Calculated according to the payments to the CCP entity and total.

Texas
Prevention Corrective Action Plan (submit upon request)

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.

2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.

3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

Prevention Attachments A, B, and C (optional)

State: Texas

Approved Substitute Data Submission Form

Substitute data has not been submitted for prevention forms.

State: Texas

Prevention Attachment D:
2005 Block Grant Subrecipient Cost Band Worksheet

Subrecipient Name:_____

Date Form Completed:_____

Name of Contact Person:_____

Phone:_____ **E-mail Address:**_____

Table 1: Progam Detail

1	2	3	4	5	6
Program Name	**Number of Participants**	**Number of Program Hours Received**	**Total Cost of the Program**	**Average Cost Per Participant (Col 4/Col 2)**	**Average Cost Per Participant Falls Within 2005 Cost Bands (Yes=1 No=0)**
Universal Direct Programs					**Universal Direct: $58.01–$693.98**
1.					
2.					
3.					
4.					
Universal Indirect Programs					**Universal Indirect $1.05–$82.26**
1.					
2.					
3.					
4.					
Selective Programs					**Selective $151.88–$6,409.29**
1.					
2.					
3.					
4.					
Indicated Programs					**Indicated $510.47–$4,888.44**
1.					
2.					
3.					
4.					

Table 2: Subrecipient Cost Band Summary

	1	2
Program Type	**Number of Programs**	**Number of Programs Falling Within Cost Bands**
Universal Direct		
Universal Indirect		
Selective		
Indicated		
Total		

Instructions for Completing the 2005 Block Grant Subrecipient Cost Band Worksheet

The 2005 Block Grant Subrecipient Cost Band Worksheet is an optional tool that States may use for their providers to record the number of program participants, the number of hours received, the cost of each program, the average cost per program participant, and the number of programs whose average participant costs fall within the 2005 cost bands. Data should be based on total cost of program not only the funding from CSAP. States may use an alternative approach to obtain data used to report the aggregate cost band data in Form P15 of the SAPT Block Grant Application. These worksheets are not required as part of that submission.

1. Subrecipient Information

Grant Information. At the top of the page, enter the name of the subrecipient, the contact information for the person completing this form, and the date on which the form was completed.

2. Table 1: Program Detail

Column 1: Program Name. In column 1, list the names of all programs that were funded in whole or in part with Block Grant funds during Federal fiscal year (FY) 2005. Add additional rows if necessary.

A program is defined as an activity, a strategy, or an approach intended to prevent an outcome or to alter the course of an existing condition. In substance abuse prevention, interventions may be used to prevent or lower the rate of substance use or substance abuse-related risk factors.

Separate table sections are provided for programs that are defined as Universal Direct, Universal Indirect, Selective, and indicated. Universal indirect services are defined as services that support prevention activities, such as population-based activities, and the provision of information and technical assistance. Universal direct, selective, and indicated services are defined as prevention program interventions that directly serve participants.

- ***Universal.*** Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.

- ***Universal Direct.*** Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, afterschool program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions).

- ***Universal Indirect***. Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.

- ***Selective.*** Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

- ***Indicated.*** Activities targeted to individuals identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels.

Column 2: Number of Participants. In this column, specify the number of participants who took part in the preventive program during FY 2005. If this intervention was delivered to multiple groups, combine all groups and report the total. If it is an indirect program, use the estimated number of people reached during the reporting year.

Column 3: Number of Program Hours Received. In this column, report the number of hours that program participants received over the course of the program.

Column 4: Total Cost of This Program. In this column, report the total of all costs expended on the program during the reporting year. This should include all costs associated with the program, such as staff training, staff time, and materials, during the year.

Column 5: Average Cost Per Participant. Report the average cost per participant. Calculate the average cost by dividing the Block Grant dollars expended on each program (column 4) by the number of participant s served (column 2).

Column 6: Average Cost Per Participant Falls Within Cost Bands. Compare the average cost per participant (column 5) with the 2005 cost bands for each program type. If the average cost per participant falls within the specified interval, record a "1" in column 5. If the average cost is either higher or lower than the cost band interval, enter a zero in column 5.

3. Table 2: Subrecipient Cost Band Summary

Table 2 summarizes information recorded in Table 1.

Column 1: Number of Programs. In column 1, enter the total number of programs on which you reported in Table 1, by program types (Universal Direct, Universal Indirect, Selective, and Indicated). Total the number of programs in the last row.

Column 2: Number of Programs Falling Within Cost Bands. For each program type, enter the total number of programs that fell within the cost bands for that program type (i.e., programs that were coded "1" in Table 1, column 5).

6/20/2007 5:03:39 PM

Texas
Description of Supplemental Data

States may also wish to provide additional data related to the NOMs. An approved substitution is not required to provide this supplemental data. The data can be included in the Block Grant appendix. When describing the supplemental data, States should provide any relevant Web addresses (URLs) that provide links to specific State data sources. Provide a brief summary of the supplemental data included in the appendix:

Texas

Appendix A - Additional Supporting Documents (Optional)

Appendix A - Additional Supporting Documents (Optional)

No additional documentation is required to complete your application, besides those referenced in other sections. This area is strictly optional. However, if you wish to add extra documents to support your application, please attach it (them) here. If you have multiple documents, please 'zip' them together and attach here.

OFFICE OF THE GOVERNOR

RICK PERRY
GOVERNOR

September 23, 2008

Barbara Orlando, M.S.
Grants Management Specialist
Formula Grant Team
Substance Abuse and Mental Health Services Administration
Office of Program Services, Division of Grants Management
1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20850

Dear Ms. Orlando:

The State of Texas is applying for funding for Federal Fiscal Year 2009 through the Substance Abuse Prevention and Treatment Block Grant. As authorized by 42 U.S.C. 300x-21 et seq. and regulated by 45 C.F.R., Part 96, the state will use block grant funds to provide substance abuse prevention and treatment services to youth and adults throughout the state's 11 health and human services regions.

I designate the Texas Department of State Health Services (DSHS) and the assistant commissioner of the DSHS Mental Health and Substance Abuse Services Division to apply for these funds on behalf of the State of Texas. I further authorize the assistant commissioner as the individual to sign documents for the block grant uniform application and to perform similar acts relevant to the administration of the Substance Abuse Prevention and Treatment Block Grant.

This designation is valid for the full length of my term as Governor of the State of Texas. If you have questions or need clarification concerning Texas' compliance with block grant requirements, current progress in meeting the goals of the block grant, and/or intended use of funds for FY 2009, please contact DSHS Mental Health and Substance Abuse Services Assistant Commissioner Mike Maples at (512) 206-5968.

Sincerely,

Rick Perry

Rick Perry
Governor

RP:dfp

cc: David L. Lakey, M.D., Commissioner, DSHS
Mr. Mike Maples, Assistant Commissioner, DSHS Mental Health and Substance Abuse Services

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STATE AND LOCAL RATE AGREEMENT

EIN #: 32-0113643

DATE: June 1, 2007

DEPARTMENT/AGENCY:
Texas Department of State Health Services
1100 W. 49th Street
Austin TX 78756-

FILING REF.: The preceding Agreement was dated August 9, 2005

The rates approved in this agreement are for use on grants, contracts and other agreements with the Federal Government, subject to the conditions in Section III.

SECTION I: INDIRECT COST RATES*

RATE TYPES: FIXED FINAL PROV.(PROVISIONAL) PRED.(PREDETERMINED)

TYPE	EFFECTIVE PERIOD FROM	TO	RATE(%)	LOCATIONS	APPLICABLE TO
FINAL	09/01/04	08/31/05	10.2	On Site	Health Programs
FINAL	09/01/04	08/31/05	29.5	On Site	Laboratory Services
FINAL	09/01/04	08/31/05	46.8	On Site	Local & Regional Ser
FINAL	09/01/05	08/31/06	10.2	On Site	Health Programs
FINAL	09/01/05	08/31/06	21.3	On Site	Laboratory Services
PROV.	09/01/06	08/31/07	11.1	On Site	Health Programs
PROV.	09/01/06	08/31/07	21.3	On Site	Laboratory Services
PROV.	09/01/07	UNTIL AMENDED	Use same rates and conditions as those cited for fiscal year ending August 31, 2007.		

*FY 2005/2006 - The base for the Department is total direct costs excluding:

Capital expenditures (individual items of equipment or capitalized construction or renovation projects).

90% of sub-recipient grant contracts costs.

100% of Title XX Family Planning client services contract costs.

100% of the Northstar client services contract costs.

WIC food costs.

*FY 2007 - The base for the Department is:

Total direct costs excluding capital expenditures (buildings, individual items of equipment; alterations and renovations), that portion of each subaward in excess of $25,000, flow-through funds and WIC food costs.

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DEPARTMENT/AGENCY:
Texas Department of State Health Services

AGREEMENT DATE: June 1, 2007

SECTION II: SPECIAL REMARKS

TREATMENT OF FRINGE BENEFITS:
Fringe benefits are specifically identified to each employee and are charged individually as direct costs. The directly claimed fringe benefits are listed below.

TREATMENT OF PAID ABSENCES:
Vacation, holiday, sick leave pay and other paid absences are included in salaries and wages and are claimed on grants, contracts and other agreements as part of the normal cost for salaries and wages. Separate claims for the costs of these paid absences are not made.

Equipment Definition -
Equipment means an article of nonexpendable, tangible personal property having a useful life of more than one year and an acquisition cost of $5,000 or more per unit.

FRINGE BENEFITS:

FICA
Retirement
Worker's Compensation
Unemployment Insurance
Health Insurance
Post Retirement Health Benefits

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DEPARTMENT/AGENCY:
Texas Department of State Health Services

AGREEMENT DATE: June 1, 2007

SECTION III: GENERAL

A. LIMITATIONS:
The rates in this Agreement are subject to any statutory or administrative limitations and apply to a given grant, contract or other agreement only to the extent that funds are available. Acceptance of the rates is subject to the following conditions: (1) Only costs incurred by the organization were included in its indirect cost pool as finally accepted: such costs are legal obligations of the organization and are allowable under the governing cost principles; (2) The same costs that have been treated as indirect costs are not claimed as direct costs; (3) Similar types of costs have been accorded consistent accounting treatment; and (4) The information provided by the organization which was used to establish the rates is not later found to be materially incomplete or inaccurate by the Federal Government. In such situations the rate(s) would be subject to renegotiation at the discretion of the Federal Government.

B. ACCOUNTING CHANGES:
This Agreement is based on the accounting system purported by the organization to be in effect during the Agreement period. Changes to the method of accounting for costs which affect the amount of reimbursement resulting from the use of this Agreement require prior approval of the authorized representative of the cognizant agency. Such changes include, but are not limited to, changes in the charging of a particular type of cost from indirect to direct. Failure to obtain approval may result in cost disallowances.

C. FIXED RATES:
If a fixed rate is in this Agreement, it is based on an estimate of the costs for the period covered by the rate. When the actual costs for this period are determined, an adjustment will be made to a rate of a future year(s) to compensate for the difference between the costs used to establish the fixed rate and actual costs.

D. USE BY OTHER FEDERAL AGENCIES:
The rates in this Agreement were approved in accordance with the authority in Office of Management and Budget Circular A-87 Circular, and should be applied to grants, contracts and other agreements covered by this Circular, subject to any limitations in A above. The organization may provide copies of the Agreement to other Federal Agencies to give them early notification of the Agreement.

E. OTHER:
If any Federal contract, grant or other agreement is reimbursing indirect costs by a means other than the approved rate(s) in this Agreement, the organization should (1) credit such costs to the affected programs, and (2) apply the approved rate(s) to the appropriate base to identify the proper amount of indirect costs allocable to these programs.

BY THE DEPARTMENT/AGENCY:
Texas Department of State Health Services
(DEPARTMENT/AGENCY)

(SIGNATURE)

Machelle Pharr
(NAME)

Chief Financial Officer
(TITLE)

6/21/07
(DATE)

ON BEHALF OF THE FEDERAL GOVERNMENT:
DEPARTMENT OF HEALTH AND HUMAN SERVICES
(AGENCY)

(SIGNATURE)

Henry Williams
(NAME)

DIRECTOR, DIVISION OF COST ALLOCATION-
(TITLE) CENTRAL STATES FIELD OFFICE

June 1, 2007
(DATE) 0710

HHS REPRESENTATIVE: John T. Glennon
Telephone: (214) 767-3266

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